To what extent EU accession provide an opportunity for the nursing leadership in Croatia and Romania to advance a professional agenda?
A comparative case study using an ethnographic approach

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Abstract

The thesis considers the views and experiences of nurse leaders and policy-makers on the use of EU accession as a policy window to advance a professional agenda in Romania and Croatia.

The research question and objectives are designed to identify the policy context prior EU accession, the processes and mechanisms employed to achieve compliance with Directive 2005/36/EC, the nursing policy agendas and achieved legislative and professional outcomes. They are analytically located within the process of Europeanisation, EU accession policy, leadership, engagement and advocacy literature. The comparative findings are interpreted within this theoretical framework.

The study adopted a qualitative approach using an ethnographic multi-method design involving interviews and documentary analysis of key EU accession primary source reports. My own positional was written into the account in a reflexive manner.

The findings indicate that the nursing leadership used EU accession as a policy window to advance a professional agenda but the extent to which this opportunity was exploited differed in the case studies. Findings indicate the importance of regime specific conditions creating a set of constraints which differed in both cases. The Croatian case shows what could have been achieved through the use of TAIEX capacity building engaging stakeholders in agenda-setting. The Romanian nurse leadership failed to take advantage of the policy window prior to EU accession but the continued advocacy hold the Romanian government post-EU accession to account for its policy decisions. Although the new generation of nurses in Romania and Croatia comply with Directive 2005/36/EC, the nursing workforce which graduated prior to EU accession does not benefit from mutual recognition. It is concluded that the EU mechanisms to process compliance – peer review and capacity building – are not robust enough to strengthen free movement based on mutual recognition.

The research findings contribute towards our understanding of the role of nursing in policy-making and the dynamics that drive policies outcomes. The research adds new knowledge to our understanding of the researched area and helps to position nursing within a broader context of EU enlargement.

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My narrative story relates to my family, 'Ant Nieke' (Leonie De Raeve) who left for London immediately after WOII as her father, my grand-father, was very demanding for women, to which she revolted and left for London. Leonie worked as a nurse in several London hospitals and in the pharmaceutical industry.

After the war, 'Ant Nieke' married 'Uncle Olly' (Oliver Miller), who she met as an army patient, being a seals man on a war ship and when settling down after WOII, designing the mosaic in St.-Paul Cathedral. In 1950, 'Ant Nieke' and 'Uncle Olly' came for the first time back to Zonhoven (Belgium), but they decided their work and life was in London. They both lived and died in Northolt, London. I visited them once in 1973.

Finally, EFN has given me this academic opportunity, while having an extremely busy and difficult lobby job in the EU. As EFN was developed in the beginning of the seventies due to the European Commission writing up the Directive on Mutual Recognition of Professional Qualifications (MRPQ), I dedicate the thesis to the free movement of nurses and nurses, women, contribution to patient and health outcomes. Gender is key for innovation, leadership and change. Gender is key for peace in the EU, Europe and the World.

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Abbreviations

CEE	Central and Eastern Europe
CDR	Democratic Convention of Romania
CINAHL	Cumulative Index to Nursing, the Allied Health Literature
CNA	Croatian Nurses Association
COSA	Council for Occupational Standards and Attestation
DARE	Database of Abstracts of Reviews of Effects
DG	Directorate-General
EC	European Commission
EEC	European Economic Community
EFN	European Federation of Nurses Associations
ENP	European Neighbourhood Policy
EP	European Parliament
EU	European Union
FSN	National Salvation Front - Frontul Salvării Naţionale
HDS	Croatian Democratic Party
HDZ	Croatian Democratic Union
HSLS	Croatian Social Liberal Party
ICN	International Council of Nurses
ICPSR	Inter-university Consortium for Political and Social Research
ICTY	International Criminal Tribunal for the former Yugoslavia
IMF	International Monetary Fund
KNS	Coalition of People's Accord
KPJ	Communist Party of Yugoslavia
MARKT (DG)	Internal Market and Servives (DG)
MRPQ	Mutual Recognition of Professional Qualifications (Directive 2005/36/EC)
MS	Member State (s)
NATO	North Atlantic Treaty Organisation
NCRED	National Centre for Recognition and Equivalence of Diplomas
NGO	Non-Governmental Organization
OAMMR	Order of Nurses, Midwives and Medical Assistants in Romania

PC	Conservative Party
PNŢCD	Christian-Democratic National Peasants' Party,
PD	Democratic Party
PDSR	Partidul Democraţiei Sociale din România
PNL	National Liberal Party
PRM	Partidul România Mare
PSD	Partidul Social Democrat
PUR	Humanist Party of Romania
RNA	Romanian Nurses Association
SDP	Social Democratic Party of Croatia
SDSH	Social Democrats of Croatia
SKH	Croatian League of Communists
SSRN	Social Science Research Network
UDMR	Democratic Union of Hungarians in Romania
WHO	World Health Organisation

Chapter 1 Introduction

This introduction sets out the context in which the study is grounded, followed by the rationale for undertaking this research. The formulation of the research questions and objectives was part of an iterative process informed by literature and appropriate methods for design of the study. The introduction concludes by guiding the reader through the contents of each chapter, and structure of the thesis.

1.1 Reflexivity

My interest in the subject of the thesis was sparked by my position as Secretary General of the European Federation of Nurses Associations (EFN), I first came in contact with European Union (EU) enlargement and accession process in 2002 as Poland's membership was being questioned – 250.000 nurses did not comply with the minimum requirements as set out in the European Directive on the Mutual Recognition of Professional Qualifications (MRPQ) (De Raeve, 2011; European Commission, 2003). When entering my job as Secretary General in March 2002, I immediately became confronted with tough and very tense Polish negotiations on the upgrading of nursing education to EU standards as set by the European Directive 2005/36/EC, as part of the *Acquis Communautaire.* The *Acquis* was the legislative vehicle used to transpose EU into national legislation prior to becoming an EU Member State (Appendix 1). I spoke on October 2002 in the European Parliament on the need for Poland to upgrade its entire nursing workforce to comply with the Directive 2005/36/EC and as such, to facilitate the free movement of Polish nurses in the EU (Appendix 2).

In 2004, Poland entered the EU with a derogation in the Directive 2005/36/EC stating that Polish nurses who studied at lyceum level – secondary level – during the Communist regime would not be recognised within the EU as their curriculum did not comply with the Directive 2005/36/EC and the Polish government did not take any measures to scale up the lyceum level of nurses' education prior to EU accession (De Raeve, 2012; European Commission, 2005; Wronska, 1998; Wojcik, 1997; Brykczynska, 1995).

The Polish case continued to form part of my lobby work until 2013, when the modernisation of the Directive 2005/36/EC took place. On 23 January 2013, the European Parliament voted on the deletion of the derogation in the Directive 2005/36/EC recognising all Polish nurses for mutual recognition of their professional qualifications as the Polish government upgraded the education of 25.000 nurses' post-EU accession, with the financial support of 50 million European Social Cohesion Funds. The Polish government, mainly the Chief Nursing Officer and the Commission unit for MRPQ agreed to skill up the workforce which is the main objective of the Social Cohesion Funds.

In line with the Polish case, a similar political discussion is ongoing between the EU institutions – the European Commission, the European Parliament and the Council led by the Irish EU Presidency (January - June 2013) – on possibly deleting the derogation in the Directive 2005/36/EC for Romanian nurses. The Romanian findings were therefore relevant for the political decisions taken in 2013 which brings upfront the duality of my position.

My position as Secretary General and researcher played an important role in the design of the study. I had the opportunity of being involved in policy discussions from a position of advantage in my capacity as Secretary General and therefore had privileged access to policy intelligence. This policy context encouraged me to understand, analyse and compare the influence of the Romanian and Croatian nursing leadership on the EU accession policy process. The legislative and professional outcomes of the EU accession process for both cases shed light on the structural barriers to leadership and how the policy drives and dynamics worked in favour of or against the professional interests of nurses in both cases. In doing so they highlight what still needs to be done to advance the nursing as a profession in Romania and Croatia within the context of mutual recognition of professional qualifications and as such the free movement of nurses within the EU. The study design therefore makes explicit the duality of my position both as a lobbyist and a researcher in EU enlargement and mutual recognition of the professions policy. It is within this context that the rationale of the research study is located.

1.2 Rationale for the study

The initial review of the policy and political science literature confirmed that there are no nursing and political science studies that examine the interplay between nurse leadership; the historic-political context in which it operated the deployment of policy mechanisms to set the policy agenda and the effect these forces had upon the legislative and professional outcomes in EU accessionResearch contributing to new knowledge about nursing leadership can generate a stronger link between research and public policy outcomes, with particular attention to developing the nursing profession within an enlarging EU.

I was therefore particularly keen to understand policy-making around the EU accession process through examination of the narratives of nurse leaders and policy-makers in Eastern Europe, mainly Romania and Croatia. The rationale for a qualitative approach envisaged that the information generated through this research contributes to increasing the understanding of nurses' influence on the development of policies and assists in designing leadership and advocacy strategies from which a new generation of nurses and nurse leaders can emerge and learn.

Furthermore, the rationale for focusing on the accession of two former Communist regime countries (Romania and Croatia), the engagement of the nursing community and, in particular, the leadership of that community within the EU accession policy-making process was to open the black box of the policy process and make it more transparent to audiences both within the policy and professional communities interested in EU accession. I am interested in analysing these two former Communist regime countries in which current nursing leaders and policy-makers trained, worked and developed their careers during the Communist regime led by Nicolae Ceausescu and Josip Broz Tito. In contextualising the comparative case study research, I argue that in both cases it is important to consider the nature of the political system alongside the contextual and historical understanding of the political and nursing leadership's role in policy-making. Although the strategic behaviour of policy-makers, politicians and nursing leaders, and their efforts to influence the terms of debate, are not unique to any one country or policy area (Wildavsky, 1987), I argue that the dynamics and the demand for political nursing leadership in shaping EU accession policies depend on the contemporary historical context within which leaders have to operate.

In addition to policy context, it is important to evaluate the available EU accession mechanisms that the nursing leadership in both cases employed to influence policy design and to advance their issues on the political agenda. Evaluation of the mechanism's robustness' in designing evidence based policies is important to understand and explain policy outcomes.

Furthermore, mapping the dynamics of the nursing leadership (professional association, nursing regulator, nursing union, governmental chief nursing officer) in setting a joined-up professional agenda and engaging in developing a National Nursing Act in compliance with the Directive 2005/36/EC sheds light on the complexity of policy-making and multi-level governance. Although leadership conjures up a variety of thoughts, reflections and images, nursing leadership can be defined as a multifaceted process working towards identifying and agreeing common goals and visions, motivating other people to act, and providing support and motivation to achieve these mutually negotiated objectives and goals (Porter-O'Grady, 2003). Leadership encompasses vision, passion and the desire to meet challenges (Bishop 2009).

1.3 Research question and objectives

The focus of the thesis is the nursing leadership's engagement in the EU accession of Romania and Croatia. This includes the extent to which nursing leaders attempted to influence the development of a national nursing legislation to comply with the *Acquis*, how these nursing leaders and the nursing profession are in turn influenced by EU policy and accession; and how nursing leaders in Romania and Croatia used the accession process to develop nursing as a profession within their countries, during and after EU accession. Consideration of the political context of the Ceauşescu and Tito regimes under which policy-makers and nurse leaders operated during Romania and Croatia's EU accession processes offers a unique contribution to understanding the policy dynamics associated with political transition. .

The research question addressed is:

> *To what extent did the EU accession process provide an opportunity for the nursing leadership in Romania and Croatia to advance a professional agenda at national level?*

The research draws on a qualitative and comparative case study to explore from an ethnographic approach the extent to which nurse leaders in Romania and Croatia used the EU accession process to formulate and implement a professional agenda and achieve policy goals.

Four specific objectives underlie the study.

> Objective 1: *To identify the context and conditions which have helped or hindered nurses to engage with the EU enlargement and accession process;*
>
> Objective 2: *To explore the processes and mechanisms through which nurse leaders have engaged specifically with the Acquis in the case study countries*;
>
> Objective 3: *To map out the policy agenda of nurse leaders and the extent to which policy goals have been achieved in the case study countries*; and,
>
> Objective 4: *To examine nurse leaders' views and experiences of the EU enlargement and accession process and the related policy-making process and outcomes at national level.*

The conclusions and recommendations drawn from the comparative case study are formulated within these four objectives.

1.4 Outline of the thesis

Chapter 2 begins with a description of EU accession. It is imperative to locate the two research sites within the different stages of the European enlargement strategy and to understand what mechanisms are employed to become an EU Member. The research study focuses on one specific area of the *Acquis* – the compliance with the European Directive on MRPQ (Directive 2005/36/EC) – and, hence, the free movement of people (in particular, nurses) within the EU. Therefore, when designing the research study, it was important to locate EU health policy and my position within the EU accession and health policy process.

Chapter 3 provides insights into the two case study countries. Setting the political and professional scene of Romania and Croatia prior to EU accession enables nursing education to be seen in context and locates the study historically.

Chapter 4 presents an examination of the theoretical literature underpinning policy-making that is necessary to develop a critical understanding of the effectiveness of the policy theories, models and frameworks in relation to a different policy and political context. In order to locate the study theoretically, the Europeanisation, policy, leadership, engagement and advocacy literature is reviewed.

In Chapter 5, I discuss some of the theoretical considerations that informed the choice of study design and the methodological decisions made during the course of data collection and analysis. The chapter includes a description of the natural history of the research, examining issues regarding access to the research participants and reflections on the relationship between the researcher and study participants.

Chapters 6 and 7 present the case study findings based on an analysis of the participants' views, experiences, policy-making roles and interests. The main aim of the research was to explore whether the EU accession process was a policy window for the nursing leadership. Therefore, these chapters describe the closure of Chapter 3 of the *Acquis* and identify how the nursing leaderships influenced the legislative and professional outcomes.

Chapter 8 critically evaluates the comparative case study findings, examining how these relate to what I found and concluded from the literature following on from my positionality. The comparative study findings showed that implementation of the *Acquis* – a condition of EU membership – opened a policy window triggering different nursing stakeholders to design new nursing legislation. However, the degree to which the nursing profession in each case study country used this opportunity varied as the dynamics to engage differed.

Chapter 9 brings together the key conclusions, using these as the basis on which to formulate recommendations in relation to the study objectives. These take account of future prospects and scenarios for case studies through considerations of policy context, mechanism, process and outcomes.

Chapter 2 The EU enlargement and accession policy process

The purpose of the chapter is to explore the difference between Europeanisation, EU enlargement and accession in addition to the process and mechanisms employed to transpose EU legislation – such as the European Directive on Mutual Recognition of Professional Qualifications (MRPQ) – into national legislation. The thesis aims to advance knowledge on the potential and limitations of the EU's leverage on aspiring and would-be members and provides insights into the domestic conditions for its success. Positioning the Directive 2005/36/EC and EU health policy within the *Acquis Communautaire* locates the study theoretically and empirically. The chapter concludes with consideration of my dual role as lobbyist and analyst and the role that reflexivity plays in understanding the research topic and knowledge claims resulting from my insider-outsider position (Sultana, 2007).

2.1 Europeanisation through EU enlargement and accession

The European Commission (EC) defines enlargement of the European Union (EU) as the process whereby countries join the EU (European Commission, 2013) implying the transposition of the Acquis Communautaire into national legislation and as such implementing the basic principles of the Treaty on the EU (Article 6.1): liberty, democracy, respect for human rights and fundamental freedoms, and the rule of law.

In 1950, the European Coal and Steel Community was set up by six countries (Belgium, Germany, France, Italy, Luxembourg and the Netherlands) in order to build the first cornerstones of peaceful cooperation (Maas, 2007; Grin, 2003). The European Coal and Steel Community developed further to become the European Economic Community (EEC) founded by the Treaty of Rome in 1957 and, subsequently, the EU in 1992 (Loth, 1990; Küsters, 1987). Different enlargement phases followed – Denmark, Ireland and the United Kingdom joined in 1973; Greece in 1981; Spain and Portugal in 1986; and Austria, Finland and Sweden in 1995 – with Europeanisation research mainly focussing on the EU's transformative power (Blavoukos & Pagoulatos, 2008; Bache et al., 2006; Boeri et al., 2002; Checkel, 2001; Cowles et al., 2001).

In 2004, the EU underwent an historic enlargement, from 15 to 25 Member States, to include 10 countries from central and eastern Europe and the Mediterranean – Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia – most of which had lived for decades under the authoritarian regime of the Warsaw Pact. With the example of Slovakia, Pridham (2002:224) has shown that EU demands may have had a strong and positive impact on democratisation in the applicant country but successful policy outcomes have depended upon the determination of individual governments, strong public support for EU accession, and mutually supportive political dynamics 'in Brussels' and the future Member States.

Romania and Bulgaria joined the EU in January 2007, giving a total of 27 EU Member States. Accession negotiations with Croatia and Turkey were agreed in October 2005, with Croatia joining the EU in July 2013. Hillion (2011:188) describes enlargement as "setting in motion the application of a specific and evolving body of EU rules that govern the entire process through which an applicant country becomes a Member State of the Union". As such, "enlargement is an integrated policy in that it entails the projection of the entire EU Acquis towards the applicant State" (Hillion, 2011:303). Becoming an EU Member States entails working towards a well-functioning democracy with stable institutions and the rule of law being guaranteed. Human rights and the protection of minorities are legally guaranteed and respected in practice. Next to these political requirements, membership of the Union requires the existence of a functioning market economy and the capacity to cope with competitive pressure and market forces within the Union (European Council, 1993). The ability to assume the obligations of membership – that is the *Acquis* as expressed in the Treaties, the secondary legislation and the policies of the Union are examined based on all chapters of the Acquis (Appendix 1).

As the EU enlarged there was corresponding expansion of its legislative framework of which the *Acquis* is but one example. The reunification of Germany in October 1990 and the fall of the Soviet Bloc made it necessary to rethink the European project (Dinan, 2006; Schwabe, 1995) and led to the production of the Treaty of Maastricht in 1992. This set out a framework for political, economic and monetary union. More EU treaties were developed: the Treaty of Amsterdam (October 1997) and the Treaty of Nice (February 2001).

These focussed on the reform of EU institutions in order to enable them to function efficiently as the EU expanded from 15 to 25 Member States in 2004. The last signed treaty, the Treaty of Lisbon (December 2007), gives more power to the European Parliament; changing voting procedures in the Council; and establishing the citizens' initiative, a permanent president of the European Council, a new High Representative for Foreign Affairs and a new EU diplomatic service. The aforementioned treaties underpin the legal status of the EU and allocate the powers of its institutions (De Raeve, 2011, 2008; Greer, 2006; Lamping, 2005; Hervey & McHale, 2004; Mossialos & McKee 2004; McKee et al., 2002).

Although Greer (2007, 2004) argued that the treaties that constitute the EU and allocate powers to the European institutions have limited impact with regards to health policy (Hervey, 2008; Lamping, 2005; Hervey & McHale, 2004; Mossialos & McKee, 2004; McKee et al., 2002), health services became part of the European Single Market of which MRPQ is a key component. The different enlargement processes since 1970 were consequently subject to compliance with the European Directives on MRPQ to which the nursing leadership contributed (De Raeve, 2011; Keighley, 2009). The study therefore looks into EU accession, defined as a process to guide and assist applicant countries in preparing economic and political obligations – implement rule of law, respect human rights, install democratic juridical system and free market economy – especially in the course of transition, reform and adoption and implementation of the *Acquis*, specifically Chapter 3 in which Directive 2005/36/EC is located. One way to understand, evaluate and explain the practical relevance and tangible results of EU accession is through case study design.

When locating the study theoretically, it is important to acknowledge Sedelmeier's (2011) conceptualisation of Europeanisation by including the dynamics of pre-accession and analysing how durable and distinctive the patterns of candidate EU accession countries are in the post-accession stage. The term Europeanisation therefore goes beyond ‘influence of the EU’ or ‘domestic impact of the EU’ (Ladrech, 2010; Borzel & Risse, 2007; Borzel, 2005; Mair, 2004; Falkner, 2003; Radaelli, 2003; Featherstone & Radaelli, 2003; Cowles et al., 2001). The study of EU conditionality in the context of EU accession broadened the conceptualisation of ‘Europeanisation’ to include applicant and candidate countries as a separate and new sub-field of the broader research agenda (Bauer et al., 2007; Grabbe, 2006; Schimmelfennig & Sedelmeier, 2005b; Hughes et al., 2004).

The study design and findings could therefore be relevant for an emerging and promising new research agenda with the Western Balkans – the Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro and Serbia including Kosovo – providing an opportunity to reassess some of the conceptual insights of the study of candidate country Europeanisation as well as the analysis of the effectiveness of the mechanisms used to 'Europeanise' accession countries to the EU (Sedelmeier, 2011; Epstein & Sedelmeier, 2008).

2.2 Mechanisms by which enlargement is achieved

One of the first steps towards accession is to examine in detail how the EU body of legislation – the *Acquis Communautaire* – became transposed into national legislation (European Commission, 2004). The *Acquis* is one of the EU's most powerful policy tools with which to implement the basic principles of the Treaty on the EU (Article 6.1): liberty, democracy, respect for human rights and fundamental freedoms, and the rule of law. Containing more than 90 000 pages of EU law, it is divided into 36 chapters reflecting the broad sectors of EU responsibility. Schüttpelz (2004) suggests that the European Commission is certainly the dominant agent in transfer of policies in the accession process with the applicant country restructuring public policies and institutional structures, although Grabbes (2002) makes reference to the fact that costly reforms – such as investments in education or the implementation of the EU health and safety at work regulation – tend to be postponed while areas expected to have high benefits, such as privatisation and competition, are given higher priority (Grabbe, 2002).

The degree of compatibility between national legislation and EU rules is evaluated within each chapter, providing a common basis for subsequent negotiations between national governments and the European Commission. The Commission may be advised on a specific piece of legislation by external experts. In that capacity, a health ministry and/or the European Commission may invite experts in nursing and mutual recognition of professional qualifications to help analyse the current state of nursing legislation and the profession at national level. Schüttpelz (2004) argues that the players with whom the Commission cooperates at the different stages of the process, and knowledge of the intentions and resources of those actors, is decisive for an empirical analysis.

The compliance policy process is supported by the European Commission's Technical Assistance and Information Exchange (TAIEX) peer reviews and capacity building seminars. TAIEX is the instrument responsible for all technical assistance elements in relation to preparations for the application of the *Acquis* (European Commission, 2011, 2010, 2009, 2008, 2007, 2006). Peer reviews have the main objective of determining whether adequate administrative infrastructure and capacity are in place to ensure full implementation of the *Acquis*. Peer review reports pinpoint areas that require further strengthening and are publicly available following discussion and approval in the Commission's national coordinators meetings, to which many governmental chief nurses are appointed.

The peer review reports tend to be an important source of information for the Commission's comprehensive monitoring reports on which political leaders from the European Commission, the European Council and the European Parliament make informed decisions on progress towards compliance with the *Acquis*. Avdagic (2001) reported that the Commission comprehensive monitoring reports do not provide a critical assessment regarding the implementation of the EU accession requirements. Also, that EU accession is handled almost exclusively by the governments, with the *Acquis* being declared confidential (Avdagic, 2001). However, these forms of peer review and reporting – the recommendations and findings captured in the TAIEX and the monitoring reports – are clearly crucial in outlining a common strategy concerning Europeanisation (Borbély 2001).

2.3 Positioning Directive 2005/36/EC within the *Acquis Communautaire*

EU enlargement is about peacekeeping, stability and prosperity but is driven mostly by the transition of a national economy into the single European market economy – the 'free movement' of people, goods, services and capital (Morlino & Sadurski, 2010; Ilonszki, 2010). Therefore, removal of the obstacles to service provision and free movement is one of the key drivers to achieve a single European market (European Commission, 2010).

The Treaty of Rome (1957) was intended to provide for the free movement of individuals. However, in the case of the health professions, Member States were not obliged to recognise

professional qualifications gained in other Member States. This major obstacle to the free movement of professionals across borders required a system to facilitate mutual recognition of education, training and qualifications. Two separate systems emerged over time: (i) sectoral directives (European Commission, 1977); and (ii) general system directives (Maciejewski, 2012; De Raeve, 2011; Inoue, 2010; Keighley, 2009; European Commission, 1977).

Under the general system directives, for any regulated profession, an individual who is recognised as a professional in one Member State must also be recognised as such in another Member State in order to practice. The directives do not stipulate any standards of education and training, with the qualifications of individuals being assessed on a case-by-case basis by the competent authority legally designated to administer the general system directive in the host country. The original Directives (89/48/EEC; 92/51/EEC) have been amended over time. In a nursing context, these Directives were applicable to nurses in all divisions of the register except that of general nurses (Keighley, 1994). Both Directives set out the provisions whereby nurses educated and trained in one Member State could apply to be assessed for registration in another, but did not harmonise education throughout Member States for the nurses to whom these Directives applied. Specialist nurses (e.g. psychiatric nurses, children's nurses, intellectual disability nurses, public health nurses and nurse tutors) fell under this regime and, if seeking to work within another country in the EU, were required to apply to the potential host Member State for recognition of their qualification and specialisation.

In contrast, the sectoral directives were prepared for seven specific professional groups: midwives; nurses responsible for general care; doctors; dental practitioners; pharmacists; veterinary surgeons; and architects. Those relating to general nurses (77/452/EEC; 77/453/EEC) were first introduced in 1977 and have been amended over time, particularly as new Member States have joined. This has led to the harmonisation of general nursing education programmes throughout the EU by setting out the minimum standards required for the nature, content and length of education and training programmes leading to a qualification which would be automatically recognised by all Member States (De Raeve, 2011; Keighley, 2003a, 2003b).

These sectoral directives also set out the provisions whereby general nurses who were educated and trained in one Member State could gain registration in another.

In 2002, the European Commission proposed that all the sectoral and general directives should be brought together in one framework (Pochmarski, 2004). Directive 2005/36/EC was developed following tense political debate between the European Commission, the European Council and the European Parliament between 2002 and 2005, the period during which I lobbied the European institutions as Secretary General of the EFN. In fact, this discussion related mainly to how far the liberalization of health services could go, including the free movement of health professionals to deliver these services. EFN members were therefore very concerned that European institutions would dilute the minimum requirements – the 4600 hours and theory/practice balance – leading to a lower qualified registered nurse in general care (EFN, 2002). After three years of active lobbying at national and European level, the new Directive was approved in the European Parliament in September 2005 (European Parliament, 2005).

Directive 2005/36/EC replaces all of the aforementioned directives, which have been repealed, and also incorporates relevant EU case law. While simplifying and consolidating existing rules and procedures, the EFN considers that this harmonised directive still guarantees better protection of the public interest and public health in the free provision of services and safeguards the legal requirement to obtain the input of the professions concerning relevant EU legislation. Furthermore, the Directive legally secures the input of the seven sectoral professions and can be both proactive (e.g. put forward a proposal for legislative change) and reactive (e.g. respond to a request from the Commission and Member States on a very specific topic, for instance, the introduction of nursing competencies in EU legislation).

Chapter 3 of the *Acquis* concerns freedom of establishment and the provision of services, including health services. This is one critical area in which an accession country must improve and demonstrate progress. This includes recognition of professional qualifications, including transposing the minimum requirements of the Directive. Compliance with the nursing elements of Directive 2005/36/EC mostly relate to four main minimum criteria:

1. a minimum entry level of general education: the Commission means 10 years of compulsory schooling, implying that individuals entering the nursing programme are at least 17/18 years old;
2. a full educational programme of 4600 hours;

3. minimum one third of the educational programme must be theoretical and minimum one half must be clinical training on a full-time basis; and
4. the nursing curriculum must include at least the study topics as described in Directive Annex 5.2.1 (Appendix 3).

Directive 2005/36/EC became operational on 20 October 2007, thereby establishing the legal basis for qualification recognition and requiring this legislation to be implemented by Member States seeking to join the EU. At this time, the Commission decided to open infringement procedures against 25 Member States for failure to communicate measures transposing the Directive of which two defaulted on account of nursing (Belgium and Luxembourg). By the end of 2009, all Member States (except Greece) had transposed the Directive; 17 of 27 Member States had fully implemented the Directive. The main reasons for late transposition and implementation mainly related to the complexity of the Directive; the volume of work in terms of regulated professions; the number of professions regulated on a national level; and the number of ministries and other competent authorities involved at the national level (European Commission, 2010).

The European Commission recognised these barriers and consequently, in December 2011, proposed a new modernised directive as one of the twelve levers for growth set out in the Single Market Act and aiming at further facilitating the mobility of professionals across the EU. Neither of the case study countries (Croatia, Romania) was exposed to this new modernised legislative proposal during negotiations.

However, the political dynamics surrounding MRPQ remain a professional challenge as the liberalisation approach tends to give the Commission more powers to draw up the curricula of the sectoral professions although education is a Member State responsibility (subsidiarity). This policy approach can be linked to health policy's increasingly prominent role within the EU aimed at tackling major societal challenges such as the ageing population and chronic diseases, and seeing health as an important indicator to create economic growth (European Commission, 2011; Greer, 2007). Nevertheless, some German politicians from the European People Party (EPP) (ENVI Committee, November 2012) dominated the political debate on nursing education in the Council and the European Parliament by pushing for a lower entry level to nursing education, a two-tier system with a 'practical' nurse and a 'theoretical' nurse. Their argument relates to tackling the elderly care challenges with a cheaper solution (lower qualified nurse), healthcare services

provided on a voluntary basis and the German healthcare system providing good patient outcomes (European Parliament, 2012). Although this discussion is beyond the remit of the thesis 2013 will be an important milestone for nursing education in the EU.

2.4 Positioning EU health policy within the *Acquis Communautaire*

As indicated above Greer (2007, 2004) argued that the treaties that constitute the EU and allocate powers to the European institutions have limited impact with regards to health policy (Hervey, 2008; Lamping, 2005; Hervey & McHale, 2004; Mossialos & McKee, 2004; McKee et al., 2002). Nevertheless, EU policy impacts on nursing (RCN, 2013). These impacts relate to the EU's public health remit, including ensuring a high level of health protection in addition to employment protection and improving working conditions, health and safety at work and working towards equal opportunities (access to care, salaries,…).

The impacts also relate to the introduction of direct negotiations between trade unions and employers in the hospital and health care sector at European level and the free movement of health professionals in Europe with automatic recognition of qualifications and minimum standards for nurse education. Cross-border healthcare with the redesign of the healthcare system by developing a network of reference centres, creating standards of care and deploying eHealth services in nursing and social care is the most recent impact which will lead to the redesign of many health systems in the EU in the years to come. It is therefore argued that the EU's explicit health and free movement remit strengthens the focus on patient safety, care quality and safe and healthy work environments and as such avoids market considerations dominating EU policy and legislation impacting on health services throughout the EU (RCN, 2013).

EU competencies in health developed even though the provisions in the Treaty of Rome (1957) rested primarily on economic grounds, with the emphasis on free movement of goods, capital, services and people. The only (rather weak) reference to health was developed in Article 129 of the Treaty of Maastricht (1992), stating that the European Community would contribute to a high level of health protection for its citizens by making provisions for action towards the prevention of major health epidemics (De Raeve, 2004).

Despite this, Community institutions retained limited scope for action, acting solely on the coordination of policies and programmes without harmonisation of law. Article 129 was described as a compromise solution between those supporting an EU mandate for health and those who saw health as an area in which they did not wish to stray, thus resulting in an ambiguous legislative article (Greer, 2005).

Article 129 was refined within Article 152 of the 1997 Treaty of Amsterdam. For the first time this stated clearly that Community action shall be directed towards improving public health, with EU institutions tasked to encourage cooperation between Member States and, if necessary, lend support to their action. This development came against the backdrop of the public health threat posed by the emergence of bovine spongiform encephalopathy (BSE) (McKee et al., 1996). Nevertheless, Article 152 once again reaffirmed that any public health action would need to fully respect Member States' responsibilities for the organisation and delivery of their health services. With EU institutions having limited scope for action in the health field, the development of EU health policy has been described as a consequence of 'spill-over': introduced in response to policies in other areas (McKee et al., 2004).

Although health services, financing and organisation of health systems are not mentioned in any treaty, a core activity of the EU – the creation of a single market through EU-wide regulations – shapes health policy at EU level (Martinsen & Vrangbaek, 2008; McKee & Mossialos, 2006; Greer, 2006b; Hatzopoulos, 2005; Hervey & McHale, 2004; Mossialos & McKee, 2004; McKee et al., 2002).

The more recent Treaty of Lisbon (2009) added some further refinement to the EU public health article as a response to the European Court of Justice rulings concerning the reimbursement of expenses incurred by patients seeking healthcare services in other Member States. Specifically, paragraph 2 of the current Article 168 adds that the EU shall, in particular, encourage cooperation between Member States to improve the complementarity of their health services in cross-border areas. Therefore, although health policy (including the organisation, financing and management of healthcare) still remains the national responsibility of Member States, the EU is increasingly undertaking health-related activities by lending support to cooperation between Member States towards protecting and promoting public health, as well as supporting Member States to plan their health workforces.

Such recent examples include joint action mechanisms not only addressing major diseases but also focussing on EU health workforce planning and the exchange and promotion of best practices in quality and safety within the existing healthcare systems.

2.5 My position within the EU accession process

A more nuanced understanding of the research findings can be gained through consideration of my position as both an insider lobbying policy-makers and politicians (as Secretary General of the European Federation of Nurses Associations, EFN) and an outsider (as researcher in EU accession).

At the same time, it could be perceived that my position biased the construction of meanings and interpretation of the comparative findings (Hammersley & Atkinson, 2007; Shiffman, 2007; Caitlin, 2007). Therefore, it is important to consider how the duality of my modus operandi might have impacted on the design of the study (Slembrouck, 2005; Falconer, Al-Hindi & Kawabata, 2002). Unveiling my own assumptions and dismantling my professional experiences as an insider in the EU enlargement and accession process situates the research study and consequently the process of knowledge production while maintaining the ethical commitments throughout the entire research process (Walt, 2008; Sultana, 2007; Peake & Trotz, 1999; Hurd, 1998; Katz, 1994; Harding, 1991).

My position played an important role in the design of the study and therefore making explicit the duality of being both the EFN Secretary General and a researcher in EU policy is central to reflexivity.

2.5.1 My position as EFN Secretary General

In 2002 I became the first Secretary General of the EFN, responsible for lobbying mainly the European Commission, the European Parliament and the Council of Ministers. Lobbying for EFN members implied setting the EU health/nursing agenda by influencing the EU legislative policy process in order to achieve successful policy outcomes for the profession.

The EU legislative lobby activities from 2002 onwards related mainly to MRPQ. The European Commission review of Directives 77/452/EEC and 77/453/EEC resulted in a harmonised Directive 2005/36/EC led by EU Commissioner Bolkestein liberalisation ambitions. Together with my colleagues representing physicians, dentists, midwives, pharmacists, veterinarians and architects – the so-called sectoral professions benefitting from the mutual recognition regime – I developed a detailed understanding of Directive 2005/36/EC and its impact on the development of the nursing profession both within Member States and in potential and candidate EU countries.

Coalition building with the sectoral professions and with civil society stakeholders was one of the EFN's strategies to set nursing matters high on the political agenda of the European institutions. Also, this was necessary to maintain the support of policy-makers and politicians concerning the EFN position on the safety and quality aspects related to MRPQ.

In October 2002 I addressed the European Parliament in my role as Secretary General of the EFN, representing 3 million nurses:

> EFN welcomes the new proposal from the European Commission for consolidating and simplifying the process for mutual recognition to free movement of professionals in Europe. ... [that as] the EU treaties contain commitments to both free movement and to a high level of health protection in all EU policies, the principle of mutual recognition, based on minimum EU nursing education standards, is about balancing professional standards, patients' protection and free movement (Appendix 2).

From 2002 to 2005 I was involved in lobbying the Commission (DG Internal Market) and European parliamentarians to continue to recognize the nursing profession as a sectoral profession which would benefit from automatic recognition of qualifications. This secures the free movement of nurses in general care within the EU and, consequently, the safety and quality of their services. Regular sectoral briefings and strategic planning meetings between the secretary generals representing nurses, physicians and pharmacists were used to keep politicians informed and to plan joint and coordinated lobby actions directed at the Commission, Council and European Parliament. Effective extension of these coalitions depended upon identifying the right partner with the right political power to increase the chances of relaying the nursing message most successfully (Greenwood, 2011).

The collaboration between the secretary generals of the pan-European organisations was based on trust and a broader common interest in public health (Greenwood, 2007). Coalition building therefore implied supporting the agendas of the other organisations so that all gained from the collaboration.

In addition, collaboration with organisations with which there was less common interest was not overlooked. Employing a multifaceted approach, EFN developed its own clear political message on patient safety and quality of care, built relationships around these political topics and explored other channels to advance the EFN position within civil society (e.g. European Public Health Alliance, the European Women's Lobby and European Patients' Forum). The aim was the achievement of the EFN's key objective: "to strengthen the status and practice of the profession of nursing for the benefit of the health of the citizens and the interests of nurses in the EU" (EFN, 2009:1).

In relation to EFN members and their impact on national governments, it was necessary to design an EFN strategic and operational lobby plan to set an EU policy agenda on MRPQ, EU workforce planning and quality and safety in order to achieve measurable policy outcomes (De Raeve, 2011). Operationalizing EFN political priorities implied identifying and maintaining a clear direction, without becoming diverted. Being reliable and trustworthy; engaging strategically with EFN members; and designing EU policies based on collaboration and intersection with other key pan-European stakeholders shaped successful EU policy outcomes. These included policies on free movement of nurses; prevention of sharps injuries; planning and skills mix of the EU workforce for health; and deployment of eHealth services in nursing and social care to re-engineer the design of healthcare systems in the EU.

In addition to lobbying policy-makers and politicians concerning the design of the European Directive on MRPQ (2005/36/EC), it became apparent that the latest wave of EU enlargement involved the enormous challenge presented by 250.000 Polish nurses who did not comply with its minimum requirements (De Raeve, 2011). The EFN wrote to the Polish authorities outlining the main weaknesses in their nursing education (Appendix 4). Consequently, I became embroiled in regular meetings in Warsaw involving tense negotiations with the nursing regulator and nursing union. While the EFN was calling for nursing education in Poland to be upgraded, the Polish

regulator and unions believed that nursing education was already in compliance with the European Directive and therefore required no further efforts prior to EU accession in 2004.

Explaining, advocating and lobbying national and European policy-makers, politicians and nursing leaders on the importance of implementing the minimum EU standards for the nature, content and length of nurses' education and training programmes therefore played an important role in choosing EU accession as the main study topic and bringing the impact of nursing leadership into the design of the research question and objectives.

My direct involvement in such negotiations raised a number of questions regarding the exploration of nursing leadership. In my position as Secretary General I wrote numerous articles to express the EFN's views on EU accession and implementation of the *Acquis*. In Nursing and Health Developments in Central and Eastern Europe (De Raeve, 2004) I addressed the question: “What holds nurses back from being actively engaged in policy-making?” arguing that: “the enlargement process of the EU provides new opportunities for leadership in nursing”. Two of my main questions in 2004 were whether, and how, the nursing leadership engaged in the EU accession policy process and whether nurse leaders saw EU accession as an opportunity to advance their agenda (De Raeve, 2005)? These publications were my first reflections on EU accession and the ‘brain drain’ of eastern European nurses to EU Member States (Hellmann, 2010; Buchan, 2007, Pittman et al., 2007; De Raeve, 2005).

My experience with the challenges concerning Polish nurses and EU accession led to my appointment (by DG Enlargement with agreement of the applicant country) as a TAIEX peer review expert to evaluate nursing education in Romania in relation to compliance with the minimum requirements set out in the Directive on MRPQ. This provided a unique insight into the views and behaviour of Romanian state and non-state stakeholders in the EU accession process. These observations inspired me to deploy an ethnographic approach to the study design. After visiting nursing education schools and clinical practice sites in Bucharest, Cluj and Timisoara in 2004, I worked within the experienced team of experts drafting the peer review recommendations tackling the identified weaknesses in the nursing legislation and nursing students' placements in clinical practices.

I was also asked to be a speaker on the TAIEX capacity building programme in Croatia. Invited as an expert on EU accession, I explained to the Croatian state and non-state stakeholders how EU institutions – European Commission, European Parliament and Council of Ministers – operate in designing new legislation and how EFN influences these European institutions in designing EU health policies (De Raeve, 2011). The key objective for capacity building was to understand how to transpose Directive 2005/36/EC into national nursing legislation and how to address the TAIEX expert recommendations identified in the TAIEX peer review report.

In both Romania and Croatia, my insider and privileged observer position as a TAIEX appointee provided the opportunity to observe what was going on in high-level policy meetings of the research inquiry. These would have been inaccessible to me in a researcher capacity. The observational data from my privileged observer status provided in-depth contextual information enabling cross-validation of the interview findings (Labaree, 2002; Becker & Geer, 1957). However, by influencing and being influenced by my role as researcher, these privileged encounters shaped my assumptions related to:

- acknowledging the position of nursing in eastern Europe – poor treatment and poor working conditions, including remuneration, which push nurses to find better career opportunities in the EU;
- recognising the opportunity to develop a pathway capitalising upon the benefits of EU enlargement and accession and thereby moving the nursing profession towards European standards, greater recognition and leadership on health system reforms; and,
- exploring the leadership practices deployed in a suppressed political regime which determine the behaviour of the nursing workforce that hampers equal opportunities for nurses within the EU.

When designing the study, I realised that my position as Secretary General of EFN made it impossible to remain detached and neutral throughout the research study (Sherman & Webb, 1988). However, I also took note of the positivists' advice encouraging researchers to remain 'outside' the world studied, so as not to lose 'objectivity' and 'bias' the findings (Fraser, 1997; Calhoun, 1994; Mbilinyi, 1992).

2.5.2 My position as researcher of the EU accession process

I considered the EU accession process of Eastern European, former Communist regime countries to be an ideal opportunity to explore and better understand the way that nursing leadership influenced the design of a national nursing Act compatible with the Directive on MRPQ. Within this context, the 'narrative story' steered the research design towards accessing political elites (Hammersley & Atkinson, 2007; Flyvbjerg, 2006; Hammersley, 1992).

Consequently, ethical considerations related to interviewing political elites, the need to use interpreters for some of these interviews and the need to guarantee participants' confidentiality informed the research design. In addition, my own policy position in the EU (Hammersley & Atkinson, 2007; Marshall & Rossman, 1999; Rainbird, 1990) could, positively and/or negatively, impact on my access to high-level policy-makers and political elites (Bondi, 2003; Moss, 2002; Jones et al., 1997). Undheim (2003) indicates that the privileged position and public image of 'famous researchers' carries a risk that they never obtain access to informants and are even unfit for interviewing. However, ethical consideration needed to be given to incorporation of 'political elites' who might use the research study and the researcher's position as Secretary General of EFN as a vehicle to articulate, strategise and advance their own ideas and political agenda (De Laine, 2000; Seldon, 1990).

Thus, it became clear that the research design needed to address adequately the ethical dilemmas posed by inequalities of power and the need for confidentiality. Despite assurances, the anonymity of participants recruited through my network of contacts could be compromised by their knowledge of, or ability to trace, each other. When designing the study, it was also important to acknowledge that participants could perceive the study as a potential threat to their position if their privacy was not adequately guaranteed (De Laine, 2000; Thomas, 1996a; Aaker, 1996). Being conscious of this discomfort, the use of an interpreter/translator needed in-depth methodological discussion concerning not only confidentiality but, equally importantly, the language barrier between the researcher and the researched.

Language incorporates values and beliefs and carries accumulated and particular cultural, social and political meanings (Bassnet, 1994). It can define differences and similarities and therefore is not a neutral medium. Furthermore, the interaction between languages (in my case English-Romanian, English-Croatian, French-Romanian and mainly English-English as second or even

third language) is important as a medium for exploring ideas, perspectives, world view and beliefs, setting up an overarching, framework for understanding (Corson, 1990; Kalantzis, Cope & Slade, 1989). To assume that there is no problem in interpreting concepts across languages is to assume that there is only one baseline, and that is the researcher's own.

Therefore, when opting for interpreters to facilitate access and story details, the study design needs to make visible both the interpreter and the researcher by highlighting the ethical and methodological tensions. The existence of multiple inconsistencies by cross-language researchers – should inform the research study design (Squires, 2009; Temple & Young, 2004; Temple & Edwards, 2002; Phelan, 1995).

2.6 Summary

Reflexivity became central to the design of the research study. My dual role as analyst and activist in the two cases made it important that my different identities and different modus operandi were understood and defined from the start of the study. Lack of transparency could impact the trustworthiness of the study and even challenge the identities (Domosh, 2003). By spelling out my EU lobby experiences, the design of the study was influenced by the following factors.

1. Political and professional difficulties occasioned by my position as Secretary General when preparing the 2004 EU enlargement wave comprising 10 countries from central and eastern Europe and the Mediterranean. The Polish case involved me in political and professional challenges immediately upon appointment.
2. My lobbying efforts in the European Parliament between 2002 and 2005 concerning the harmonisation of the EU legislative framework which safeguarded the MRPQ principle.
3. My European Commission appointment as an expert for TAIEX – for both peer reviews and capacity building. This was when I started to explore with my supervisor the feasibility of a MPhil/PhD study; and
4. My own assumptions in relation to the positioning of nurses and nursing in Eastern European countries which recently moved from totalitarian regimes to democracy and the leadership needed to enjoy the benefits of EU enlargement.

Therefore, I am specifically interested in analysing Romania and Croatia, two former Communist countries that joined the EU in 2007 and 2013, respectively. Supplementing my own EU experience of lobbying with information from what did and did not work for nurse leaders in Eastern Europe can enable better understanding of the impact on policy-making that results from nurses' leadership and advocacy capacity. The focus of the thesis will be researching EU accession, compliance with the *Acquis*, and the nursing leadership's role in the policy process to develop the nursing profession through the design of new legislation.

Preparations for the fifth and sixth EU enlargement waves reached their full potential during the research study but negotiations on future accessions (with Turkey, Iceland and all the countries of the Western Balkans – the Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro and Serbia, including Kosovo) are ongoing. This research is therefore timely: exploring not only nursing leadership but also the effectiveness of the mechanisms by which EU accession is managed. Hence, it is important to explore whether the compliance policy process, consisting of mechanisms to transpose policies (in this case Directive 2005/36/EC), are 'fit for practice' and provide an opportunity for the nursing leadership to influence the political and professional agenda.

The study provides an opportunity to reassess the EU's accession conditionality related to Directive 2005/36/EC and the effectiveness of the mechanisms employed to reform nursing education and to europeanise the acceding countries (Sedelmeier, 2011; Epstein & Sedelmeier, 2008). The thesis aims to advance knowledge on the potentials and limits of the EU's leverage on aspiring and would-be members and provide insights into the domestic conditions for its success.

Chapter 3 Political and professional scene setting

This chapter documents the contextual and historical background for the two case study countries, Romania and Croatia, particularly the political context and how nursing developed during the Communist regime. The key goal of this chapter is to provide an overview of developments and regime change overtime with a clear link to locating nursing education and profession prior to EU accession. This allows evaluating theoretically if nursing in Romania and Croatia can be positioned prior EU accession as a profession.

In Romania and Croatia, contemporary nursing leaders and policy-makers grew up during the Ceausescu and Tito regimes, respectively. Although the strategic behaviour of policy-makers and their efforts to manipulate the terms of debate are not unique to any country or to any policy area (Wildavsky, 1987), consideration of the political context of the regimes under which policy-makers operated during Romania's and Croatia's EU accession offers an insight into the dynamics of influence under conditions which have hitherto been largely unexplored. Hence, the political context in both Romania and Croatia is important for understanding not only the way that policy-makers and nursing leaders operated and influenced EU accession process but also sheds lights on the position of nursing as a profession and the impact the development of the nursing profession has on the achieved legislative and professional outcomes prior to EU accession.

3.1 Positioning Romania politically

Romania achieved independence from Russia and became a constitutional monarchy in 1878 (Moraru, 2001). In 1924 the Romanian Communist Party was banned because of its ties with the Soviet Union but continued to operate underground (Shafir, 1997). A fascist movement (later called the Iron Guard) was founded by Corneliu Codreanu in 1927 and grew in strength during the 1930s (Boia, 2001; Deletant, 1995; Veiga & Gărzii de Fier, 1993).

The operations of Securitate – Romania's Secret Police – is something Romanian citizens, including nurses, grew up with and is likely to have impacted on the behaviour of the nurse leaders and policy-makers, interviewed all of whom were born between the mid-1950s and early 1960s. (Gallagher, 1995; Baleanu, 1995).

In August 1939, Soviet leader Joseph Stalin signed a non-aggression pact with Adolf Hitler, carving up Eastern Europe into German and Soviet spheres of influence. Romania was occupied by Germany during World War II and fell behind the Soviet Union's Iron Curtain at its conclusion (Hale, 1971). With Soviet backing, the Romanian Communist Party took control of the government and proclaimed the Romanian People's Republic in April 1948, with a Stalinist constitution (Tismăneanu & Kligman, 2001; Frunză, 1990).

From the 1960s until the end of the 1980s the Communist Party of Romania, led by Gheorghe Gheorghiu-Dej and his successor Nicolae Ceauşescu, began to implement a foreign policy independent of the Soviet Union (Almond, 1988). Internally, Romanians continued to be controlled by the secret police (Securitate) and Ceausescu's family who governed Romania (Hignett, 2010; Deletant, 1999). Ceauşescu intended to modernise the Romanian economy but squandered much of the nation's remaining wealth after returning from a visit to China in 1980 with the ambition of implementing political ideas, including the creation of the second biggest building in the world (Shafir, 1985; Montias, 1967). As an example of the character of the regime – referred to by Shafir (1985), Calinescu and Tismăneanu (1992), Gallagher (1996) and Linz and Stepan (1996) – is the case of the construction of the *Casa Poporului* [House of the People]. The construction required the demolition of much of Bucharest's historic district, including 19 Orthodox Christian churches, 6 Jewish synagogues, 3 Protestant churches and 30.000 homes (Moraru, 2001). Ceauşescu specified a boulevard wider than the Champs Elysees and a 'palace' to host the Communist Party administration (Almond, 1990). Construction lasted from 1981 until 1988, with costs estimated at €2 billion (Carey, 2004). During the regime change, the new political leaders referred to the *Casa Poporului* as the House of Ceauşescu to highlight the excessive luxury in which he lived, in stark contrast to the squalor and poverty endured by many people living in Romania at the time (Carey, 2004; Hunya, 1998).

Furthermore, the Ceauşescu years, in which nurse leaders and policy-makers negotiating EU accession grew up, were dominated by lies, corruption, terror, violations of human rights and isolation from the Western world (Scarpitta, 2008; Bruvere, 2003; Cioroianu, 2002; Tismăneanu & Kligman, 2001; Brykczynska, 1995). Boari and Gherghina (2009:12) emphasised that 'the Ceauşescu regime succeeded in depraving the way people think and perceive reality'.

The opening of Romanian secret police archives for the first time since the fall of communism in 1989 showed the impact of Securitate on the behaviour of Romanian citizens, including nurses (Bjel, 2004; Gallagher, 1995; Baleanu, 1995). Nelson Duque (2011) describes in 'Inside Ceausescu's Romania: An Unquestionably Efficient Police State' how the lives of many Romanians were dominated by fear. Lavinia Stan (2002) describes fear as the method for recruitment of informants, threatening and blackmailing routinely to coerce informants: refuse the 'offer' of informing implied ending up on the Securitate black list, marked as an 'enemy' or opponent of the state. This notorious Securitate continues to haunt Romania today as many former high-ranking Securitate officers still hold key positions in politics and business (Hignett, 2011; Mutler, 2009; Lungescu, 2009). As the 2009 Nobel Prize winner for literature Herta Mueller (2009) indicates: 'Ceausescu's secret service isn't dissolved, it simply renamed itself' (Bjel, 2004; Butler, 2003).

The European Parliament condemned the Ceauşescu regime for the violation of human rights and the suffering imposed upon ordinary citizens (Papadimitriou & Phinnemore, 2008; European Parliament, 1989a, 1989b, 1991). In mid-December 1989, anti-government demonstrations erupted in the country's cities. Ceauşescu fled when the Romanian army joined the uprising against him but was arrested by the new provisional government, tried and executed (25 December 1989).

The nursing leadership found itself in a collapsed economy, inefficient state institutions, a highly politicised and unaccountable judiciary and public administration, corruption, political apathy and mistrust (Scarpitta, 2008; Gallagher, 1995). This political context and institutional legacy inherited from communism, as argued by Grabbe (2007), determined how the EU influence worked and affected the outcome of Europeanization. Grabbe (2001) argues that accession conditions and negotiations privilege a relatively small group of central government officials over other political actors and the lack of engagement of civil society and even parliamentarians into the EU accession process could, in turn, exacerbate the EU's own democratic deficit after enlargement. Dăianu (2001) – member of the Romanian Academy since 2001 and Member of the European Parliament for Romania (2007-2009) refers to the winners and losers of Europeanisation. Nevertheless, the political class that replaced Ceauşescu in 1989 – Ion Iliescu and the National Salvation Front (Frontul Salvării Naţionale, FSN) – formally committed to pluralist politics, free

elections, establishment of market economy, and the respect of the country's national minorities (Stan, 2002, Lawson, et all., 1999).

The Romanian Government submitted its formal application for EU membership in June 1995, five years after the Romanian Revolution (Prisãcaru, 1996). This was supported unanimously by the major Romanian political parties (Christian-Democratic National Peasants' Party, PNŢCD; National Liberal Party, PNL; Social Democratic Party, PSD) that all reappeared on Romania's political stage along with the Party of Social Democracy in Romania (PSDR) and the Democratic Party (PD), which resulted from a split of the National Salvation Front (Ion Iliescu). Economic and security considerations, along with a fear of being excluded from mainstream western institutions, were among the most significant motives underpinning the application for EU membership (Gallagher, 2004; Phinnemore, 2000).

The PDSR (Partidul Democraţiei Sociale din România) lost political power in 1996 following the election of the four-party parliamentary coalition known as the CDR (Democratic Convention of Romania), led by Emil Constantinescu and backed by the PD and the Democratic Union of Hungarians in Romania (UDMR). It has been widely argued that a radical contribution to the victory of the CDR came from the failure of Iliescu and his party to generate economic recovery and improve democratic standards (Tismăneanu & Kligman, 2001; Mungiu-Pippidi, 1999; Shafir, 1997).

In this period, the nursing leadership continued to be confronted with Victor Ciorbea (1996) and Radu Vasile's (1998) weak political leadership as Prime Minister. This politically weak leadership based on the legacy of Communist party rules impacted negatively on the first European Commission *Opinion on Romania's Application for Membership of the European Union (EU)* which stated that EU accession negotiations should not be opened (Commission of the European Communities, 1997a:111). At the end of 1997, only half of the EU's directives and regulations had actually been transposed into national legislation (Phinnemore, 2000). Although the opinion noted shortcomings in guaranteeing civil liberties, protecting the rights of national minorities, rooting out corruption and improving the work of the courts, the Commission concluded instead that "the current improvement in Romania, following the arrival in power of a new government, indicates that Romania is on its way to satisfying the [Copenhagen] political criteria" (Commission of the European Communities, 1997a:114). However, the first Accession Partnership for Romania,

adopted by the European Council in March 1998, spelled out the short and medium term priorities to be addressed by the Romanian authorities in order to meet the accession criteria.

The Member States (MS) (15) also invited Romania to submit a National Programme for the adoption of the *Acquis*, with a timetable for achieving compliance with the priority areas set by the EU (Official Journal, 1998). Among the most important priorities identified by the MS were: macroeconomic reforms, the privatisation of state-owned companies and of the banking sector, legislation protecting foreign investments and regulating the financial market, the adoption of civil service reforms and harmonisation with the EU's competition law (Vachudova, 2004; Moravcsik & Vachudova, 2003; Grabbe, 2001). This shows that from a MS perspective, there was no political pressure to put the sectoral directive, including nursing, on the political accession agenda. Even when reviewing the Accession Partnership in 1999, 2002 and 2003, nursing was neither a targeted priority nor a listed shortcoming in the Commission reports.

On the importance of Romania joining the EU, the western European states became confronted with the ten-week military confrontation between the North Atlantic Treaty Organisation (NATO) and Serbia over Belgrade's maltreatment of the Albanian population in Kosovo. The growing fear of instability in the Balkan region and the explosion of ethnic conflicts in Yugoslavia highlighted the fragility of the democratic process in post-communist states. This led the EU to reconsider its strategy vis-à-vis the region, including Romania (Jacoby, 2006). In this context, the Romanian political class used the Balkan war to better position Romania for EU accession negotiations. As Papadimitriou and Phinnemore (2008:31) noted: "*Whilst widely mistrusted in Brussels, the Romanian government was able to exploit international and regional security risks in order to convince EU policy-makers that possible exclusions from the EU association process would undermine Romania's transition and destabilise the wider Balkan region*".

In 1999, the European Commission published the second Regular Report on Romania's progress towards EU accession. Again, serious concerns with Romania's economic performance was expressed (Commission of the European Communities, 1998a:22) and the conclusions did not read any better, noting that "Romania had made very little progress in the creation of a market economy and its capacity to cope with the competitive pressure and market forces has worsened" (Commission of the European Communities, 1998a:50). As Papadimitriou and Phinnemore (2008:42) noted, "Implicit in the conclusions was a clear sense of disappointment with the efforts

of the post-1996 governments that had promised so much". Indeed, the CDR alliance had committed to extensive state reforms but it proved too factious and unable to live up to its commitments. Many of the reforms promised were not implemented, and the lack of political consensus among the coalition members slowed down the introduction of far-reaching institutional and policy changes. As such, the recommendation to start EU accession negotiations was conditional on the improvement of the situation of children in institutional care and the drafting of a medium-term economic strategy (Freyberg-Inan, 2002; Hunya, 1998). A decision of the Helsinki European Council (1999) set the start date of EU accession negotiations with Romania as 15 February 2000.

The newly appointed Prime Minister Mugur Isarescu (December 1999 – November 2000, Independent), an economist and head of Romania's Central Bank since 1990, changed the Romanian economy with some modest economic growth in 2000. However, these efforts were politically too little and too late as Romanians sealed the defeat of the CDR coalition in the parliamentary elections in December 2000 (Ronnas, 1991). PDSR (renamed in 2001 Partidul Social Democrat, PSD) and its leader Ion Iliescu returned to power after a head to head second round of presidential votes with Corneliu Vadim Tudor and his ultra-nationalist Greater Romania Party (Partidul România Mare, PRM). President Constantinescu did not run for a second mandate fearing a poor electoral performance (Mungiu-Pippidi, 2001). Iliescu's return to the political stage was regarded in the West as a setback for Romanian democracy (Gallagher, 2001; Mungiu-Pippidi, 2001; Tismăneanu & Kligman, 2001).

At the Copenhagen Summit in December 2002, 2007 was set as the target date for Romania to join the EU, although major shortcomings in the legal transposition and the implementation of the *Acquis* were identified: only 13 out of the 31 chapters of the *Acquis* had provisionally been closed. According to the Commission the weaknesses of Romania administrative capacity posed major constraints (Commission of the European Communities, 2002a). Consequently, the European Commission pushed in November 2002 towards the development of a roadmap containing a detailed list of short and medium term actions to be fulfilled in order to comply with the criteria for EU membership (Commission of the European Communities, 2002b). Also the European Parliament became extremely vocal on the state of the rule of law in Romania.

In 2004, a motion by Baroness Emma Nicholson de Winterbourne - the EP Rapporteur for Romania - openly called into question Romania's membership prospects, expressing serious preoccupations with the country's democratic standards. According to the EP, finalising the negotiations in 2004 and becoming member of the EU in 2007 would be impossible unless Romania took drastic action to fight corruption, ensuring judiciary independence and guaranteeing media freedom. Emma Nicholson's harsh criticism of the treatment of children in orphanages led to the European Council (June 2004) setting a safeguard clause which could delay Romania accession to the EU by one year (Jacoby et al., 2009; European Parliament, 1991, 1989a, 1989b).

Politically, Adrian Năstase (December 2000–December 2004, PSD) became responsible for the lack of progress made and it was Călin Popescu-Tăriceanu (from December 2004 until December 2008, PNL) who become confronted with a large-scale peer review mission indicating strong evidence of political interference in the justice sector and the challenge to tackle political corruption (European Commission, 2004; Pelkmans, 2003). Other areas with shortcomings were the competition legislation, especially in the field of state aid, as well as taxation and compliance with the EU's environmental legislation showing a lack of will to comply with the EU's conditionality targets (Pridham, 2006).

Romania's economic performance remained the main challenge as confirmed by Eurostat data. The Gross Domestic Product percentage (GDP%) indicate that Romania had the lowest GDP per capita in 2001 at 28%, (with an EU average of 110%).This increased during the EU accession negotiations to 49% in 2011, which is still half the EU average (Eurostat, 2012).

Although progress has been made in economic turnover expressed in GDP%, the official poverty rate of 7% in the beginning of the 1990s had increased to 18.6% in 2006 (World Bank, 2009) indicating a small segment of society became wealthier, while the majority of the Romanian population moved into poverty, including nurses. To escape poverty, even without benefitting from MRPQ, data from Sanitas Federation of healthcare workers and the Healthcare Workers Solidarity Federation indicate that Romanian nurses moving to other EU Member States increased between 2002 and 2005; 2500 Romanian nurses moved to Italy, 1200 to Hungary, 500 to Germany and Switzerland and 600 to the UK. The Unions confirm that the migration of nurses is due to the low of average monthly gross wage ranging between €110 and €360 (Ciutacu, 2007;

Muller, 2007). It is within this economic context that the nursing leadership engages with EU accession.

Despite the existing political, economic and social challenges, on 14 December 2004 Romania provisionally completed all negotiations of the *Acquis* with Romania government being forced to accept a special postponement clause in the Treaty of Accession to keep up the political pressure: delay membership by one year in case of a failure to comply with a highly detailed list of commitments (Vass, 2008). By signing the Treaty of Accession (April 2005), Romania became subject to a strict monitoring process by the Commission and Parliament. In October 2005, the Commission Comprehensive Monitoring Report praised the government's efforts with the European Commission giving the green light for Romania accession in September 2006. However, to ensure that Romania would continue implementing the reforms after accession, the Commission introduced a post-accession monitoring mechanism to verify compliance in the field of judiciary reforms and anti-corruption, but not in nursing. Despite evidence that some crucial reforms were far from compliant, the need to safeguard the Commission's credibility and the EU's enlargement policy shifted the balance in favour of accepting Romania in 2007 (Bieber, 2012; Noutcheva, 2006b).

When positioning Romania politically, economically and socially prior to EU accession, it could be argued that the nursing leadership capacity was influenced by:

- the views and experiences related to the control operations of Securitate and the necessity of ordinary citizens to operate underground to avoid getting on the black list of the secret police. As indicated by many authors, including the 2009 Nobel Prize winner Herta Mueller, the secret police activities are still part of the Romanian political and policy psyche;
- the average monthly gross wages ranging between €110 and €360 (Ciutacu, 2007; Muller, 2007) makes nurses leave Romania prior to EU accession (Sanitas Federation of healthcare workers and the Healthcare Workers Solidarity Federation, 2007);
- continuous political instability from 1998 until EU accession in 2007, with inefficient state institutions, highly politicised and mistrusted politicians and the Commission acknowledging the political interference in the justice sector and hardly any convincing track-record in tackling political corruption; and,

- the policy-making process determined by emergency ordinances to bypass the traditional legislative democratic processes which makes it impossible for nurse leaders to engage in the EU accession policy process.

The analysis of the political, social and economic circumstances of Romania over time indicates that opportunities for the nursing leadership to use the EU accession as a policy window was limited. To help us understand the role of the nursing leadership in EU accession, an understanding of the history and evolution of nursing education is needed taking into account the nature of Romanian economic and political challenges prior to EU accession. Outlining the Romanian nursing education prior to EU accession and its implications for the nursing leadership to influence the EU accession process will facilitate a better understanding of the achieved outcomes.

3.2 Romanian nursing education before EU accession

It is relevant to contextualise the history of nursing within the wider political and policy context in which the EU accession process took place.

The inception of nursing education in Romania began to develop in 1775 in Cluj (Gulie, 2011; Suvaiala, 1997; Glocotici, 1996). In 1842 the Eferia civil hospitals founded a school for surgery which represented the first step towards an organised nursing education in Romania (Bocec, 1978). The school was operational until 1847 and resumed activity, together with courses for barbers, at the Hospital Filantropia in 1853. Dr Davila re-founded this school in 1855, merging with the school of civilian medical assistants (felceri civili) to form the School of Surgery in Mihai Voda. In 1879, Dr Severeanu founded the first Sisters of Charity School – the Institute of Sisters of Charity Queen Elizabeth being considered the first school of modern nursing education (Bocec, 1978). Subsequently, the number of nursing schools increased, especially outside Bucharest in areas such as Craiova and Galati.

After World War I, an important development was the inception of education to train public health nurses. In 1919, Professor Moldovan opened the first school in Cluj. Led by Lucia Bologna Puscariu, the school offered a three-year education in public health nursing with support from the Rockefeller Foundation in the United States (Gulie, 2011; Saunier, 2008). In 1929, this became

the Institute of Public Health Nursing in Iasi under the directorship of Eugenia Costres. In 1936, institutes for public health nursing were established in Cluj and Bucharest. The Institute of Public Health Nursing, Queen Maria employed nursing teachers who had acquired their skills outside Romania – in the USA, France and Austria. For example, the Director of the Institute, Dr Eugenia Popa, trained as a nurse in Nashville, USA. Students and teachers lived in the school at which students studied personal hygiene; ethics, philosophy and psychology in relation to patients and colleagues; and economics. After four months, students were required to pass an exam in order to continue the course (Gulie, 2011).

The system of nursing education in Romania changed again after World War II, in keeping with Soviet model reform (Reform of education Decr.175/1948). Institutes of public health nursing were closed and, from 1948 to 1955, medical-technical schools produced medical assistants (*felceri medicali*). Thus, nursing education became a sanitary secondary education, with an entrance level of 14 years of age, offering no sense of autonomy, little teamwork and no understanding of the complementarity between nursing and medicine (Gulie, 2011). Much of what is normally regarded as nursing was undertaken by doctors – managing nursing/health care at ward level – or was not done at all. A total of 8000 *felceri medicali*, hygienists (*igienisti*) and obstetricians (*mamosi*) were trained. In parallel with these schools, sisters (*surori*), midwives (*moase*), sanitary officials (*oficiant sanitary*), dental technicians (*technician dentar*) and assistants (*laborant*) were trained on 6–18 month courses following their primary education (four or seven years). Over 60 000 nurses (*cadre sanitare medii*) were trained from 1955 with a secondary training insufficient to reach standards expected elsewhere in many European countries (Gulie, 2011). It is mainly this sanitary secondary education, with 14 years of age entry level, no autonomy at all and no understanding of the complementarity between nursing and medicine that locates nursing prior to EU accession.

The low level of training prompted the establishment of post-secondary-level sanitary schools providing a three year training programme (Decr. nr. 14/1955), training medical assistants with a clinical and paramedical orientation, entering the training at the age of 16. In 1965, the professional school system for training sisters, midwives and sanitary officials was introduced (Gulie, 2011). From 1967 until 1978 sisters and sanitary officials were trained through the secondary-school-level Health School, at that time the only structure for training nurses in Romania. In 1971, the National Training Centre for Nurses was established in Bucharest,

developed from a project supported by the World Health Organization (WHO). The director, Gabriela Bocec, established close contact with the International Council of Nurses (ICN) and WHO officials, provided a more professional view and reintroduced nursing into Romania.

In 1989, Gabriela Bocec organised the first course on nursing in Mangalia. In 1990, with the agreement of the Romanian Government, the post-secondary sanitary school was funded to train nurses in conformity with EU standards, through a three-year, 4600-hour programme (Gulie, 2011). In 1996, specialist nursing courses in management, education, community nursing and mental health started at the National Centre, organised on a one-year basis with the support of the *Sindicat Sanitas*.

Nursing education at the secondary level reflects a technical bias and the transition to higher education did not occur in Romania prior to EU accession (Gulie, 2011). The trend towards vocationalism in the 1970s and 1980s kept nursing in the vocational and technical schools and as such 'nurses' are still called medical assistants (Tóthová & Sedláková, 2008). As an example, documentation is a task that Romanian nurses do not perform. Other than recording vital signs, medical assistants do not document any of their nursing activities, including medication administration, nor do they record their patient assessments (Bludau, 2010). Consequently, the nursing profession agenda setting could comprise policy efforts to comply with the Directive 2005/36/EC minimum requirements:

1. a minimum entry level to the Romanian nursing education prior to EU accession is 14 years, meaning that general topics, such as mathematics present in all nursing curricula and languages are part of the nursing curricula.
2. a full educational programme of 4600 hours is reached but consists of content belonging to the general education and not to nursing.
3. one third of the educational programme is theoretically based but no nursing theory is teached. It is a medical and technical oriented education. As one half must be clinical training on a full-time basis, this criteria is not met as the placements are evaluated by physicians, not by nurses and are only hospital based.
4. the nursing curriculum does not include the programme as described in Directive Annex 5.2.1. What is missing is the ethics and the autonomy of the nursing profession.

The contextualisation of nursing education history within the wider political policy context indicates the minimum requirements as set out in the Directive 2005/36/EC were not met prior to EU accession. Although achieving compliance is crucial for the free movement of nurses within the EU, the Romanian nurses' move to other EU MS under the general system (Chapter 2), on a case by case evaluation of their curriculum, as the secondary education does not meet the Directive minimum criteria to benefit from mutual recognition.

3.3 Positioning Croatia politically

This summary of Croatia's position prior to EU accession negotiations is based on different literature sources and is intended to orientate the reader to the political context in which nursing leaders and policy-makers in Croatia grew to professional maturity during the Communist regime led by Josip Broz Tito and Franjo Tudjman.

The Croatian Communist Party – from 1952 the Croatian League of Communists (SKH) – was founded in 1937 as the Croatian branch of the Communist Party of Yugoslavia (KPJ) within the Kingdom of Yugoslavia and remained the ruling party of the Socialist Federal Republic of Yugoslavia from 1945 until the 1991 (Henderson, 1997; McAdams, 1997; Glenny, 1992). The reasons for a specific Croatian branch were partly ideological, partly practical.

Ideologically, communists were increasingly marginalised in Croatian political life due to the public's preoccupation with ethnic issues and Croatia's position within Yugoslavia (Ramet, 2006; Benson, 2001; Banac, 1988). Nevertheless, the Communist platform of post-war reorganisation of Yugoslavia on a federal level attracted many non-Communist Croatians to its cause with Yugoslavia adopting a federal structure in 1945 and Croatia becoming a republic (Hall, 2011).

Practically, Croatia was the most industrialised part of Former Yugoslavia, with the largest percentage of the working class in the population, adopting during Communism a free market economy. This is due to Josip Broz Tito reforming policies in the late sixties to symbolise a new generation of Communist leaders – for example, Savka Dabcevic-Kucar and Miko Tripalo who started the Croatian Spring which was intended to secure greater autonomy for Croatia (Fischer, 2007; Stipe, 2004). They lobbied against centralism which disproportionately benefited the eastern parts of Yugoslavia, especially Serbia and Macedonia. Franjo Tudjman, who joined the

Partisans in 1941 and believed that a new federated Yugoslavia would guarantee more the rights of the Croatian nation, became one of the leaders of the Croatian Spring but was sentenced to two years' imprisonment for counter-revolutionary activity and "hostile activity against the State" in 1972 (McAdams, 1997). The movement created significant ethnic tension and increasing opposition from more conservative party members (Banac, 2010). In December 1971, Tito publicly distanced himself from the Croatian Spring, leading to the end of the movement and subsequent purging of most of the Croatian Communist Party's liberal and reformist elements. As a result, during the 1970s the SKH became one of the most conservative sections of the Communist Party, retaining old ideological and political beliefs while other branches began to explore new ideas. In 1980 Tito died and the slow disintegration of Yugoslavia began as the 'Croatian Spring believers' asserted their desire for independence (Stipe, 2004). When the Serbian Communist Party under Slobodan Milošević adopted a more nationalist stance in the late 1980s, the SKH was slow to react. It was not until 1989 that it began open condemnation of Milošević following Serbian nationalist demonstrations in areas that would later become the Republic of Serbian Krajina (Fischer, 2007; Wilcoxson, 2004; Bennett, 1995).

In November 1989, Tudjman and his newly formed HDZ issued an appeal to the citizens of Croatia and the Communist-controlled Parliament calling for a new multi-party government. In 1990, the Croatian Parliament voted to legalise opposition parties and grant freedom of political affiliation (Coll, 1993). Over the next few months, the SKH tried very hard to present itself as a reformist party, rebranding itself as a new party that would ultimately become the Social Democratic Party of Croatia (SDP). These steps failed to convince the Croatian electorate and the SKH lost power to Tudjman's Croatian Democratic Union (HDZ).

In April and May 1990, the first free elections in half a century were held in Croatia. Some 20 political parties competed for seats in Parliament including the HDZ; SKH; and the Coalition of People's Accord (KNS), an alliance of moderate nationalist parties including the Croatian Social Liberal Party (HSLS), the Social Democrats of Croatia (SDSH), and the Croatian Democratic Party (HDS), as well as many prominent veterans of the Croatian Spring (Fischer, 2007; Sherwell, 1992). Newly established party systems are far from being stable and kept changing through the time (Mair, 1997).

Tudjman's right-wing HDZ won the election with 205 of 349 seats; the Communists secured 77 seats. Tudjman was elected President of the Republic and, in July 1990, Parliament removed the word "socialist" from the country's name and ordered that the red star be removed from all state symbols. Tudjman and the Croatian government then sought a new confederation with other republics of Yugoslavia. Croatia and Slovenia subsequently declared independence in June 1991, following which Tudjman became the first President of the independent Republic of Croatia (Hall, 2011; Fischer, 2007; Ljubojevic, 2007).

That same year, Milosevic, the son of a Serbian Orthodox priest and a hard-line Communist school teacher, sent tanks to the Slovenian borders, triggering a brief war that ended in Slovenia's secession. The whole Balkan region entered into a bloody, tragic ethnic war between 1991 and 1995 (Hammond, 2004; Gagnon, 2004; Dusan, 1991). Consequently, the EU accession became conditioned to the full cooperation with International Criminal Tribunal for the former Yugoslavia (ICTY), implying the arrest and transfer of individuals suspected of war crimes, as well as granting ICTY access to evidence, documents, and witnesses (Freyburg & Richter, 2009; Jovic, 2006; Petak, 2006). Domestic politics of cooperation dealt with several controversial war crimes indictments which impacted on the start of EU accession negotiations. To evidence the sensitivity for the Croatians, on 25th December 2002 fourteen members of the Croatian Academy of Arts and Sciences and forty-four university professors made a request to the Croatian government not to extradite indicted general Ante Gotovina (Jovic, 2006).

Croatia submitted its formal application for EU membership in February 2003 with the Council of Ministers granting Croatia official candidate status in June 2004. Due to the failure to deliver General Gotovina to the ICTY the European Council decided on 16 March 2005 to postpone the opening of the EU accession negotiations. In October 2005 the EU resumed negotiations after the Chief Prosecutor for the ICTY – Carla Del Ponte – reported that Croatia was cooperating fully with the Tribunal. Two months later, General Gotovina was arrested in the Canary Islands and transferred to The Hague. Consequently, it was only during the 2007 parliamentary elections that social issues, the welfare system and economy came on the agenda of Croatian politics instead of nationalistic ideology. At the end of June 2011, the Commission announced the conclusion of six years of negotiations over Croatia's entry into the EU knowing the accession of Croatia was to serve as a prelude to the integration of Bosnia-Herzegovina, Serbia, Montenegro and Macedonia into the EU at a later date (European Commission, 2011).

When positioning Croatia politically, it could be argued that the nursing leadership capacity prior to EU accession became mainly influenced by:

- The domination of political life by nationalistic ideology with no space for social issues, the welfare system and economy on the political agenda of Croatian politics.
- The nationalist stance of Slobodan Milošević and demonstrations triggering a brief war that ended in Slovenia's secession but entered the whole Balkan region into a bloody, tragic ethnic war between 1991 and 1995 with democratic regime building coinciding with state building and post-war reconstruction; and,
- EU accession criteria being extended with the additional criterion of full cooperation with International Criminal Tribunal for the former Yugoslavia (ICTY), implying the arrest and transfer of Croatian suspected of war crimes.

In view of this political policy environment, the nursing leadership faces some major challenges prior to entering the EU. Therefore, in addition to considering the nature of the evolution of Croatia's political system since World War II, it is important to explore how the Croatian nursing education facilitated or hindered the Croatian nursing leadership to influence policy-makers and politicians during the EU accession process.

3.4 Nursing education in Croatia before EU accession

Nursing education in Croatia has a long history in comparison to other eastern European countries (Šimunović et al., 2010). The first school for assistant nurses was founded in Zagreb in 1921. At that time, Professor Andrija Štampar (one of the founders of WHO), held a high political position in the League of Nations and gave nurses and nursing a prominent place within public health education (Štampar, 1946). Štampar argued that medicine had an exclusively curative character and neglected prevention and its social aspect to the advantage of clannish privileges and paying patients (Dugac, 2005). Štampar developed strong links with the Rockefeller Institute which enabled the subsequent development of several eastern European nursing leaders (Saunier, 2008). The period after World War I was characterized by intensive public health work; Štampar educated in the spirit of modern public-health ideas, spreading throughout Europe under the influence of the Health Section of the League of Nations and the Rockefeller Foundation (Dugac, 2005).

The cooperation between the Rockefeller Foundation and the Kingdom of Serbs, Croats and Slovenes (Yugoslavia) was very active during the 1920s, when Andrija Štampar had a position in the Ministry of Public Health. The School of Public Health in Zagreb developed an intensive programme of educating medical officers, physicians, nurses and other healthcare professionals.

Early Croatian nursing education focused mainly on providing nursing services within the anti-tuberculosis institutions, on health promotion and socio-health aspects of community care. The duration of nursing education was increased gradually – set at one year in 1921, one and a half years in 1922 and two years in 1923 (Lapeyre & Nelson, 2011; Čukljek, 2005). In 1934 the school attracted nurses who entered continuing education abroad since there was a growing need for nursing staff in Croatia. There were suggestions that nurses should have access to postgraduate studies within the faculties for social medicine at the medical universities in Croatia but these ideas were never realised. In 1926, nurses founded the first Croatian Nursing Association to deal with problems concerning working time, holidays and uniforms; this was granted ICN membership in 1929. In 1933 the Croatian Nursing Association began publishing the nursing journal *Nursing World*.

After World War II the entry requirements for nursing education stipulated a minimum age of 17 years, thus already in compliance with the minimum requirement of the current European Nursing Directive. At that time the nursing curriculum lasted three years but the programme was extended to four years in 1948 (Kalauz, 2008). Aspirations for postgraduate studies were realised between 1950 and 1953, when the Andrija Štampar School of Public Health in Zagreb organised a postgraduate training programme for nurses in public health. Those who completed the three-semester programme received a public healthcare nursing diploma. The aim of the programme was to enhance nurses' competencies in areas of general and specific patient care including dietetics, prevention of diseases, teaching and public health.

In 1953, the Nursing School for Higher Studies (Colleges) was founded and integrated within the Andrija Štampar School of Public Health and continued its work under the name of the Academy for Nurses (Kalauz et al., 2008; Dugac, 2001). In total there were five colleges: in Zagreb, Osijek, Rijeka, Split and Pula. However, all 'Colleges for Nurses' were closed in 1959, until 1967, with the introduction of legislation on secondary schools, which was a political and economical decision: the colleges were too expensive and as there ws a shortage of nurses in the hospitals,

‘cheaper nurses’ needed to be produced. Many secondary schools for nurses opened across the country (e.g. in Osijek, Rijeka, Karolovac, Varaždin, Pula, Zagreb, Dubrovnik and Split). The secondary level education in this period was composed of four years training after completion of primary school (Šimunović et al., 2010). The nursing curriculum was designed to prepare nurses to perform patient care and 'health of social security', referring to community service and counselling centres’. The Nursing School for Higher Studies in Zagreb reopened in 1967 as the College of Nursing and health technicians, with two pathways to become a nurse (outpatient and hospital-patronage) and four streams for health technicians. The requirement for admission to the Nursing School for High Studies was having finished high school with the training lasting only for two years. Consequently, both periods in the history of Croatian nursing education created the main challenges for Croatia in the EU accession and compliance process. The superficial approach to nursing education (only medically and technically orientated) employed during that time had devastating consequences. In hospitals and institutions for primary healthcare, nurses with a higher degree were replaced by nurses with the secondary school degree. This influential political signal from the Tito regime had negative impacts on nursing education and the position of nurses in society as the principle of ‘all workers are equal’ implied the downgrading of education (Potrebica, 2004).

As with the earlier Communist regime, nurses’ education was financed by the health institutions and hospitals and therefore was influenced by the political status of policy-makers. Titoism allowed some degree of free market enterprise (market socialism) and intellectual freedom was tolerated, but the dogmas of brotherhood and unity were not publicly criticised (Stipe, 2004). Tito, in contrast to Ceauşescu, is remembered more as a ‘soft dictator’ who brought stability to a turbulent region with a long history of ethnic conflict (Synovitz, 2010).

Tito’s Communist Party had support in both ethnic Croat and Serb areas, but Belgrade was the main centre for policy decisions relating to the development of nursing education (Croatian Participant 1, 3, 5, 13). The Belgrade Association for Healthcare Professions had three to four times more nurse members than the 27 000 members of the Croatian nursing community. Consequently, it was impossible for Croatian nursing leaders to change anything in the profession or the nursing care process, as they lacked a voice in the Belgrade Association of Healthcare Professions.

In 1980, the option of full-time studies was revoked. Only those referred by a health institution run by Communist party members, and granted a special contract and permission to study nursing, were able to take up nursing studies (Potrebica, 2004). In 1984, the nursing curriculum was modified and fully implemented when the Academy for Nurses merged with the University of Zagreb into a single scientific teaching institution. In 1986, a unified programme of education was introduced. This focused on the profession of nursing although the education lasted only two years and the requirement for enrolment was a secondary school diploma (WHO, 2000). Analysis of the TAIEX peer review shows clearly the reform of higher education for nurses in 1999, as most eastern European countries were moving towards democracy (European Commission, 2004). Nursing education was extended to three years; the curriculum was enriched with new subjects in the field of health care; and the vocational content amounted to over 60%. Secondary school education was not changed, remaining a four-year course with practical classes covering one fifth of the total curriculum and only half of the theoretical classes oriented on the profession.

In 2000, the Croatian Nurses Association (CNA) began preparations for a Croatian Nursing Act (Romac, 2005), a legal framework for the activities, duties and responsibilities of nurses. During the Balkan War, the leadership of the CNA developed the nursing regulator (chamber) and established a close relationship with the nursing union and the government chief nurse. The latter would later play an important role in influencing the key negotiator for Directive 2005/36/EC. A core curriculum for all nursing academies in Croatia was developed only in 2005 (Šimunović et al., 2010; Romac, 2005) (Appendix 8).

Prior to EU accession, nursing education was at secondary level within the vocational and technical schools and as such 'nurses' were called medical assistants which curriculum does not comply with the Directive 2005/36/EC minimum requirements:

1. a minimum entry level to Croatian nursing education is 14 year, meaning that general topics, such as mathematics present in all nursing curricula and languages are part of the nursing curricula;
2. a full educational programme of 4600 hours is met but consists of content derived from general education and not to nursing;
3. one third of the educational programme is theoretically based but no nursing theory is taught. It is a medical and technical oriented education; and,

4. the nursing curriculum does not include the programme as described in Directive Annex 5.2.1. What is missing are taught elements related to the ethics and the autonomy of the nursing profession.

The contextualisation of nursing education history within the wider political policy context indicates the minimum requirements as set out in the Directive 2005/36/EC are not met prior to EU accession. Although achieving compliance is crucial for the free movement of nurses within the EU, Croatian nurses' will move to other EU MS under the general system (Chapter 2) as the competent authorities will probably not recognise the secondary level educated nurses within the regime of mutual recognition.

3.5 Professionalisation of Nursing

Understanding the achieved legislative and professional outcomes prior to EU accession, and the processes of influence on policy-making in both countries, raises the question of the implications for nursing as a profession in Romania and Croatia. As Davies (2007) argues the 'old professions' are characterised by elitism, paternalism, authoritarianism, highly exclusive knowledge, control and detachment, the perception of being considered as a profession entails acknowledging the gendered notion of professionalism, the level of autonomy and the level of education (vocational, higher and university level).

Although EU accession is not a professionalisation strategy, educational and regulatory requirements played a prominent part in the negotiations and agenda of EU accession. Since both these factors are crucial in setting the entry gate to the profession they form an integral part of the case for professionalism (Abbott, 1991; Lester, 2010). Although Abbott (1991:356) argues that there is no consensus in the literature about the exact sequence of events that professions should pass on their way to develop from an 'occupation' (nurses being considered as workers) to a 'profession' (nurses being professionals), Lester (2010) sees professionalisation as a process by which any occupation transforms itself to levels of highest integrity and competence. Defining professional demarcation and grades (e.g. difference between healthcare assistant and registered nurse) implies closing the profession from entry by non-qualified workers and as such creating a homogenous group of membership.

According to Lester (2010), the professional demarcation is the process whereby nursing transforms itself into a profession by (i) having a unique body of knowledge and values (teaching and implementation of the nursing theories); (ii) having controlled entry to the group (regulation and certification); (iii) demonstrating a high degree of autonomous practice (being independent from another profession); (iv) having its own disciplinary system and (v) enjoying the recognition and respect of the wider community (Lester, 2010). This implies that regulation becomes key to the concept of professionalisation while the sociological project of professionalisation relates more to the heterogeneity and instability within and between professions (Sanders & Harrison, 2008).

The sociology of the professions has focussed on defining criteria, as Davies and others point out, predicating upon the case of the traditional professions thus leading commentators such as Etzioni (1969) and others in the 1960s to denigrate the claims of other 'lesser' professions such as nursing and teaching (both heavily gendered) as 'semi-professions. Weberian approaches in the 1980s, such as Larkin (1983) and latterly Saks (1995) and Witz (1992) focussed on the process of professionalisation rather than the 'scorecard' approach. They argued that occupational closure was the defining feature of being a profession.

Clearly, in the context of EU accession, and in the case of Croatia and Romania in particular, there were multiple entry points into the nursing profession. On this basis alone nursing would not meet the conditions set by sociologists for occupational closure in many EU countries. Moreover the lack of autonomy over the conduct of their own affairs, the concentration of power in individuals rather than democratically elected officials for professional bodies and the degree of medical domination would probably make a case for professionalism difficult to uphold. It is not clear however that the nurse leaders themselves insisted on such claims, on the contrary there is very little evidence to substantiate this. It is therefore more appropriate to think about the state of professional nursing in these countries as being in a state of transition, moving along a developmental pathway, but one which might not conform precisely to the Anglo-American models which have dominated the study of professions.

3.6 Summary

Political history and context are an important part of the assumptive world of policy-makers and nursing leaders. They can impact on the process of designing new policies and consequently affect both policy and professional outcomes. Without history arguably there can be no understanding of policy development today; and without history there can also be no realistic evaluation of policy outcomes.

The starting point in which the Romanian and Croatian nurse leaders enter EU accession differs from an economic and political perspective. While the Croatian nurse leaders lived through a well-functioning free market economy, Romanian nurses and their leaders were brought up in an environment of severe poverty. The Romanian nursing leadership found itself in a collapsed economy, inefficient state institutions, a highly politicised and unaccountable judiciary and public administration, corruption, political apathy and mistrust. Politically speaking, party instability was more obvious in Romania than Croatia although both countries have the communist regime as common legacy.

Although Romania and Croatia differ on the political and economic conditional EU membership criteria, the status in which nursing education locates itself post-communism is quite similar in Romania and Croatia: nursing education at the secondary level reflects a technical basis and the transition to higher education is not perceived by policy-makers as a necessity to develop the nursing profession and healthcare system. The nursing profession policy window therefore relates to bringing national nursing legislation in line with the Directive 2005/36/EC minimum criteria – entry level of 10 year, educational programme of 4600 hours, of which one third theory and one half clinical training on a full-time basis, and coverage of the Directive Annex 5.2.1 listed topics.

Therefore, when designing the research study, it was regarded as important that the research objective focuses on how each nursing leadership developed its own strategies and tactics to influence the EU accession policy processes. It can be argued that nursing education and the development of nursing as a profession must be located within a political and economic context. In both cases, these unstable political contexts pose specific challenges to nursing education and the profession in relation to the EU accession process and the *Acquis*. The requirement to apply Directive 2005/36/EC on the MRPQ gives nursing leaders in both countries the opportunity to steer the policy process in designing educational structures in line with the minimum standards

set out in the Directive 2005/36/EC. Until Romania and Croatia can submit curricula demonstrating compliance with the Directive 2005/36/EC, Romanian and Croatian nurses will not achieve mutual recognition of professional qualification in another EU Member State.

This implies the EU accession process focussed on setting an educational and regulatory framework for credentialing. While these components do not in themselves determine professional status; EU accession can provide a policy window for developing nursing as a profession through the establishment of a common set of credentialing standards across health jurisdictions. Insofar as control over areas of knowledge and expertise are key for professionalisation, the study explores the use that was made by the nursing leadership of EU accession in pursuing a professional agenda as distinct from pursuing a professionalising agenda per se.

Chapter 4 Literature review

This chapter reviews the political and social science literature relevant to nursing leadership engagement in the development of national nursing legislation. This forms part of the implementation of the *Acquis Communautaire* that is a prerequisite for EU membership. The review explored literature relevant to the research question: *To what extent did the EU accession process provide an opportunity for the nursing leadership in Romania and Croatia to advance a professional agenda at national level?*

The main objective of this chapter is to consider the relevance and applicability of the policy theories for the subject of study, to identify gaps and interpret the body of knowledge related to policy-making. As the study concerns EU accession, the literature review starts with the Europeanisation literature. This is followed by a critical analysis of the existing policy-making theories, models and frameworks, highlighting their strengths and limitations related to the study subject matter. The policy literature is weak on understanding the influence that non-state stakeholders (i.e. independent of government) exert on policy, and on addressing sector-specific themes such as designing nursing legislation to comply with European Directive 2005/36/EC. Hence, the literature review is extended to the engagement, leadership and advocacy literature. The review aided formulation of the discussion chapter as the findings are benchmarked against existing knowledge in the different fields reviewed. Examination of the policy, engagement, leadership and advocacy literature has been useful to understand better the complexity of the policy-making process and provides the rationale for design of the study.

4.1 Search strategy

The literature review approach was iterative, systematic, comprehensive and practical emergent (Booth, 2012). A systematic review aims to provide an exhaustive overview of literature relevant to a research question: “To what extent did the EU accession process provide an opportunity for the nursing leadership in Romania and Croatia to advance a professional agenda at national level? (Booth, 2012; Dugdale, 2009).

The systematic review used therefore exclusion and inclusion criteria for the selection of literature to be considered (Hannes, 2011): the nature of the study topic (EU accession and nursing leadership in policy-making), the study setting (Eastern European enlargement, in specific Romania and Croatia) and the sample studied (nurse leaders, policy-makers and politicians), next to the date of empirical research related to EU accession (since 1990, the collapse of Communisms) and the research methods used.

Being wary of introducing bias by adding certain inclusion or exclusion criteria, special attention was given to language. The literature review selected mainly English written literature but articles in French, German and Dutch were also included as these are languages I can read fluently. The main inclusion criteria related to literature on Romania and Croatia written in English or other appropriate language on themes related to EU enlargement and accession next to nursing education.

Nevertheless, the apparent scarcity of political and policy science literature in Romania and Croatia was a challenge. Although an extensive list of Romanian and Croatian literature was identified for review with the support of colleges in both countries (see references), language was a barrier to detailed analysis of these sources. Consequently, the literature written in Romanian and Croatian was rejected. The critical appraisal guidelines were helpful to assess the rigour or quality of studies for inclusion (Hannes, 2011).

The comprehensive search of an extensive range of online databases (health, nursing, management) took place between 2005 and 2013. More than 30 000 health-care journals are published each year so effective and efficient searching becomes a real challenge when the social and political science literature is included. This was addressed by using bibliographic indexing databases that enabled rapid searching across a large number of journals to locate references to articles on the topic of inquiry (Dugdale, 2009). The search strategy aimed to identify both published and unpublished studies reported in English/American, French, German and Dutch, using a three-step strategy.

The initial phase consisted of a search of the Cumulative Index to Nursing, the Allied Health Literature (CINAHL) online database and Medline for information retrieval in biomedicine and health. Databases including social and political science and humanities literature (e.g. Scopus, TRIP, and Web of Science) were searched extensively to identify relevant references falling outside the health sphere. Specific attention was given to the political science literature through electronic searches of Research Gate, the scientific research network; the Social Science Research Network (SSRN); and the Interuniversity Consortium for Political and Social Research (ICPSR). These databases were searched using various combinations of subject headings: 'policy', 'policy-making', 'policy-process', 'EU accession policy process', 'policy development' and 'policy theory'. Although the policy literature was the starting point of the literature review, other domains became linked including the literature on European integration and Europeanisation; on governance and leadership; and on the Balkan states entering the EU. Thus, a snowballing effect occurred in the literature review (Booth, 2012).

Although at the start of the literature reviews the main databases consulted were Medline (using the PubMed service by keywords, authors, journal etc.), the Cochrane Library (a collection of databases containing high-quality independent reviews and abstracts) and the evidence-based Cochrane Reviews, the consultation did not deliver the expected outcomes of articles published on the research topic. Therefore, the Database of Abstracts of Reviews of Effects (DARE) was useful as a source of abstracts of systematic reviews focused on the effects of interventions used in health and social care. This database is owned by the Centre of Reviews and Dissemination in the National Institute of Health Research. Through the King's College London facilities, the CINAHL database provides a comprehensive bibliographic index and includes abstracts and full text materials from selected journals. Relevant literature was collected by using keywords – such as 'EU accession', '*Acquis Communautaire*', 'Directive 36/2005/EC' and 'policy process' – to search these major databases for published articles. In addition, each review article provided references and sources which were accessed through the same databases or other library facilities. Appropriate keywords were also used in a direct Internet search using search engines such as Google to obtain information not included in peer-reviewed journals (e.g. conference reports, disease-specific or thematic web sites).

A combined keyword search in the different databases was used to select articles for review and led to interesting cross references. Key words such as 'Europeanisation', 'policy theories' and 'policy engagement', including terms such as 'EU accession', 'policy-making process' and 'stakeholder approach', were also used in isolation and in combination for additional searches of the Google search engine. Most articles were maintained as electronic copies so that they were accessible during the whole process of data analysis and thesis writing. It is through this review of the broader research topic that a focused research proposal was formulated.

4.2 Europeanisation literature

The first point to emerge from the literature was the distinction drawn between European integration and Europeanisation (Graziano & Vink, 2008; Ladrech, 1994). The former is concerned with the process of institution-building and political integration at the European level, while the latter denotes the consequences of the European integration process which may have a variable impact on the domestic politics of EU Member States (MS) (Bulmer & Lequesne, 2002; Cowles, Caporaso & Risse, 2001; Hix & Goetz, 2000; Börzel, 1999; Knill & Lehmkuhl, 1999). However, there is a lack of agreement on the concept of Europeanisation and so a range of meanings and approaches are attached to the term (Buller & Gamble, 2004; Kassim, 2000).

The research agenda has moved away from Ladrech's original definition of Europeanisation as 'an incremental process re-orienting the direction and shape of politics to the degree that the European Community's political and economic dynamics become part of the organisational logic of national politics and policy-making'(Ladrech, 1994:256). As such, the term becomes "something to be explained rather than something that explains" (Gualini, 2003:626). Europeanisation demands explanation of what goes on inside the process rather than a simple black-box design in which the input 'EU independent variables' is correlated to the output 'domestic impact'. However, new studies on Europeanisation are tending to move away from Europeanisation as a process of downloading (Brussels deciding on national policies) decision processes and the development of institutional structures. Instead, they are researching how domestic change is processed and the patterns of adaptation (Megie & Ravinet, 2004).

The second point to emerge from the literature was the opposition research approach of Claudio Radaelli and Tanja Börzel, both political scientists with connections to the European University Institute in Florence. Drawing her evidence mainly from the field of EU environmental policy, the latter defines Europeanisation as: “a process by which domestic policy areas become increasingly subject to European policy-making” (Börzel, 1999:357). Accordingly, Börzel identified the factors likely to impact on Europeanisation: (i) the good fit between EU objectives and the existing reality; (ii) the extent to which there is political will to enact new policy or build new partnerships within a particular area; (iii) the actual reform or objective; and (iv) the discursive framing and particular politicisation of the issue (Börzel, 2003). Over more than 20 years of research on Europeanisation, Börzel (2012) continues to see Europeanisation as a two-way process in which national governments upload their policies to the European level to minimize costs by then downloading them at domestic level. Thus, MS adapt to Europeanisation by deploying strategies that reflect their own preferences and interests by influencing the formulation and definition of EU institutional functioning and policy-making (Börzel, 2012; Falkner et al., 2005; van der Vleuten, 2005; Knill & Lenschow, 2001, 1998; Héritier et al., 2001; Green Cowles et al., 2001; Haverland, 2000; Duina & Blithe, 1999).

In contrast, Radaelli (2003:30) gives an alternative definition of Europeanisation: “the processes of (i) construction, (ii) diffusion and (iii) institutionalisation of formal and informal rules, procedures, policy paradigms, styles, ‘ways of doing things’ and shared beliefs and norms, which are first defined and consolidated in the EU policy process and then incorporated in the logic of domestic (national and subnational) discourse, identities, political structures and public policies”. This is grounded in an understanding of Europeanisation as an interactive process (Salgado & Woll, 2004:4). Radaelli approaches Europeanisation as “a logic of domestic political actors’ frame of reference” (Surel, 2000); “change due to EU pressures and without presupposed pressure”; and “a process consisting of complex sequences and time patterns” (Radaelli, 2004:10). The emphasis is on three modes of governance in the EU policy process: (i) negotiating policies; (ii) governing hierarchically; and (iii) facilitating coordination and cooperation.

It becomes clear from the review that Radaelli opposes Börzel's approach, calling it the "simplistic life-cycle of policies" (Radaelli, 2004:5). But they do share elements – Radaelli's vertical Europeanisation corresponds with Börzel's uploading and downloading. However, Radaelli's approach emphasises more explicitly the cultural, attitudinal and informal aspects of domestic politics and stresses the interaction between state (government-led) and non-state (non-governmental) stakeholders. Although Exadaktylos and Radaelli (2010) undertook a quantitative analysis of 46 political science articles on Europeanisation published between 1997 and 2009, Europeanisation research becomes available at a very the theoretical level while systematic empirical evidence is still lacking. Therefore, in order to further design the research study, exploring the dynamics of pre- and post- EU accession to process domestic change in Romania and Croatia next to exploring the nursing leadership, influence and advocacy in the policy process to move towards compliance with Directive 2005/36/EC, is key to answer the research question. Therefore, a critical review of the Europeanisation literature helps to locate the study design:

Firstly, there is still bias in country selection in Europeanisation research, both in terms of the choice of old (Austria, Belgium, Denmark, Finland, France, Germany, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden) or new MS (Cyprus, Hungary, Malta, Poland, Slovakia, Slovenia) with new and applicant countries (the Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro and Serbia including Kosovo) being left out of the Europeanisation equation. Europeanisation must also be understood from a central and eastern European perspective as these countries were exposed to the Soviet-style socialism that imposed political, social and economic homogeneity between the late 1940s and 1989. The study design acknowledges that the process of legislative transformation is part of Europeanisation. Thus, the concept of Europeanisation is important as it offers a framework for measuring the overall impact of EU legislation in post-socialist states in terms of compliance and engagement (Fagan, 2010; Grabbe, 2006). Nevertheless, Fagan (2010) highlights that a country being considered for EU entry may well display lower levels of Europeanisation than anticipated despite having met the conditions of enlargement and successfully adopted all tenets of the *Acquis* (Fagan, 2010).

Secondly, given that the study focus is on comparing two MS – Romania and Croatia – in the process of joining the EU, it is important to recognise (as argued by Moravcsik & Vachudova, 2004) that EU membership can remain purely a matter of net national interest in which the accession policy process is dominated by inter-state negotiations driven by achieving a credible

EU membership and the financial benefits attached (Schimmelfennig & Sedelmeier 2005b). As such, a rather disparate group of post-socialist and post-conflict states seeking to join the EU for financial gain have an important perspective on Europeanisation, especially after the 2009 economic and financial crisis affecting the EU, Europe and the world. Consequently, a distinct Europeanisation research approach is needed to embrace the particular socioeconomic characteristics of the post-Communist countries (Matei & Ani, 2010). Within this context, it is equally quite easy to forget that the EEC came into existence in 1957 in order to advance the economic interests of post-war capitalist European liberal democracies.

Thirdly, the Europeanisation literature focuses on all actors, state and non-state stakeholders, at European and domestic level with an overemphasis on national governments and political parties. There is little evidence of detailed empirical analysis on Europeanisation impact on the engagement of non-state actors, or vice versa.

But, as a critical component of Europeanisation, civil society's role in good governance is dependent on the engagement of nongovernmental organisations – not only as agents of development, implementation and law enforcement, but also as policy actors countering the influence of the state and the market (Fagan, 2010; Klüver, 2009; Mahoney, 2008; Dür/de Bièvre, 2007a; Michalowitz, 2007; Nicholson, 2005a). Börzel and Buzogány (2008) explored the factors that promote and impede effective implementation of parts of the *Acquis*. They concluded – at least for Greece, Portugal, Spain, Hungary, Poland and Romania – that adoption of, and adaptation to, the *Acquis* did not involve systematic introduction of new modes of governance to address mounting implementation problems. Furthermore, review of the Europeanisation literature does not reveal any reference to the nursing profession being part of civil society despite being the largest health-care professional interest group in the EU. Consequently, the nursing profession lacks theoretical and empirical knowledge of the role of nurses (generally women) and nursing in Europeanisation. Research can promote a better understanding of Europeanisation in the neglected area of sector-specific patterns and mechanisms employed by nurse leaders from former Communist-regime countries.

Fourthly, the Europeanisation literature has moved away from measurement of the EU's impact on domestic development towards EU enlargement and accession being part of Europeanisation. Policies related to competition, the internal market and trade and regulation, together with fiscal

and monetary economic policies and environmental policies feature prominently in Europeanisation research. Despite this proliferation of research, there is a lack of empirical studies on the meaning of Europeanisation related to variation and implementation of health policy. Although it is recognised that the EU has no direct competence in health care due to subsidiarity, the free movement of nurses within the EU is considered as one of the 12 levers of the European Single Market for boosting growth and strengthening confidence (Barnier, 2012). Also, migrating nurses can impact on health-care services delivery, health system sustainability and public health when patient safety and quality of care are affected. Consequently, the empirical comparative studies will help theorising Europeanisation.

Fifthly, the recent conceptualisations of Europeanisation as an 'export' – particularly in the context of the EU's eastwards enlargement – has been utilised to illustrate the impact of the EU beyond its own geographical confines (Papadimitriou & Phinnemore, 2008, 2004; Grabbe, 2003; Lippert et al., 2001; Goetz, 2001b). The principle of conditionality - one of the key components of the EU's strategy in post-communist central and Eastern Europe - is widely acknowledged to be the driving force behind the process of enlargement-led Europeanisation (Smith, 2005, 1998; Pridham, 2002). Although Ladrech sees the prime concern of any Europeanisation research agenda the validation of the impact of the EU on domestic change (Ladrech, 2010:2), more detailed empirical assessments of the EU's influence as its "transformative power", as Grabbe (2006) termed it, is needed. Grabbe warned about the generalised tendency in much of the literature to over-estimate the Europeanisation effect of EU conditionality on the CEE candidates arguing that "a systematic examination of the limits of the EU's impact as well as its extent is essential because the effects may not have been as great as commonly supposed" (Grabbe, 2006: 41-42). In a similar tone, Schimmefennig and Sedelmeier (2005:2) pointed out how "the process of Europeanisation in the CEECs and its outcomes has rarely been subjected to a systematic, theory-oriented and comparative analysis". This approach argues to incorporate domestic factors into theoretical frameworks and empirical analyses examining the conditions for the success or failure of the EU's leverage (Vachudova, 2008; O'Dwyer, 2006a; Pridham, 2005; Hughes et al., 2004; Jacoby, 2004).

Sixthly, it is equally important to understand Europeanisation as a discourse in which the actors (stakeholders) assess and judge reality according to their norms, values and principles. In turn, discourse is cast in different forms, from rhetoric (Schimmelfennig, 2001) to policy narratives

(Radaelli, 1999). It has transformative power in EU policy and politics as it can change the views, perceptions and preferences of the actors; reformulate policy problems; make an engagement style more confrontational or more cooperative; and increase or decrease the value of resources according to the level of political priority. Given this, the study design incorporates the discourse of the nursing leadership influencing the policy process.

Although the Europeanisation literature has been criticised for being too focused, whether on intergovernmental stakeholders and outcomes or on supranational actors and outcomes, it is important that the study design includes the idea of multilevel governance as a system involving institutions, stakeholders and processes on different levels of society (Underdal, 2008). Consequently, it is worth considering the extent to which the political system in which the literature is generated shapes its content and, by extension, the thinking and theorising about policy theory, processes and outcomes.

One of the main merits of the Europeanisation literature is that it has provided the missing link between theories and scholarly research on democratisation and regime change. By taking into account conditionality and power asymmetry between the EU and the post-communist country, research can help to conceptualise in a more accurate way the mechanisms and scope of post-communist transition in post-communist Europe (Checkel, 2007; Grabbe, 2006, 1999; Schimmelfennig & Sedelmeier, 2005; Vachudova, 2005; Dimitrova, 2004; Dimitrova & Pridham, 2004; Kelley, 2004; Ekiert & Hanson, 2003; Linden, 2002; Pevehouse, 2002; Zielonka & Pravda, 2001; Rupnik, 2000; Whitehead, 1996).

Nevertheless, political scientists do not allocate a theoretical power to Europeanisation and consequently focus on bringing together concepts and themes related to the policy process. This requires review of the policy analysis literature to identify the uploading of policy theories, frameworks and models into the concept, rather than the theory of Europeanisation. Furthermore, many authors refer to Europeanisation as governance, not as a leadership strategy, so it is equally important to review the governance and leadership literature in order to provide a different insight on the Europeanisation discourse.

4.3 Policy theories and models

A rich diversity of approaches to understand the nature of the policy process has developed over time (Warne, 2008). In *Theories of the Policy Process*, Paul Sabatier (2007) provided an important point of comparison for better understanding of policy theories, models and frameworks. Significantly for this discussion, most scholars have focused on exploring policy theories in democratic systems, mainly in the United States and Western Europe. Therefore, a critical commentary on the key policy theories, models and frameworks developed in democratic systems is part of the study design; exploring their strengths and weaknesses to understand better the development of national policies in former Communist countries applying for EU membership.

Three major approaches to policy-making theories can be discerned in the literature. The first is the rational choice theory approach. This emphasises the empirical-analytical development of policies, focusing on statistical precision and orientation towards cost/benefit emphasis to address efficiency and effectiveness (Garson, 1986).

The second is the incremental theory approach that embraces policy-making as a kind of *carpe diem* approach. These two extreme approaches led to the third approach in which scholars from different academic disciplines – sociological, organisational or political – developed a mass of policy theories, models and frameworks.

The *linear* or *stages heuristic model* provides an example of the rational choice theory approach in which policy-making is outlined as a problem-solving process – a rational, balanced, objective and analytical step-by-step progression (Lasswell, 1951). The linear model's main limitation is that it takes little account of the context and individual actor engaged in the complex interactions of the policy environment; or of the impact of the individual actor's behaviour influencing the policy-making process. The model tends to neglect the collective influence of actors at different and broadly accepted stages of the policy process – agenda-setting, formulation, implementation, evaluation (Sabatier, 2006a). A variant of the linear model, the *systems analysis framework* (Easton, 1965) defines the policy system as: "a set of interactions, abstracted from the totality of social behaviour, through which values are authoritatively allocated for a society." Easton's theory is a statement of what makes systems adapt, survive, reproduce and change. Consequently, most developed policy-system models look at government as an organism which responds to demands and actors support leading to outputs (Campbell & Mazzoni, 1976).

Subsequently, policy theories were developed in reaction to the rational choice approach. Scholars such as Rebecca Sutton (1999) argue that pluralism and incrementalism would move policy exploration away from linearity and rationality. It is argued that policy can best be understood as a "chaos of purposes and accidents" (Sutton, 1999:6). Interestingly, Sutton believes that deploying a combination of concepts and tools from different scientific disciplines would bring order to the chaos of policy-making – including policy narratives, policy communities, discourse analysis, regime theory, leadership change theories and the role of interest groups.

Hawkesworth (1988) criticises both rational and incrementalist scholars for sacrificing citizen engagement in favour of technically informed elites. Thus, she concurs with Peter deLeon's (1983) argument that policy-making should promote direct and meaningful engagement of citizens. This is not the case when theories are created and applied independently of events, outside the operational field of the researcher.

The policy literature saw a marked shift in the terms of debate from the late 1980s to at least the early 2000s. Scholars such as Elinor Ostrom, John Kingdon, Frank Baumgartner, Frank Jones, Bryan Jones and Paul Sabatier reacted against both the predominance of the linear stages heuristic approach and the incorporation of normative theory by looking for explanatory theories of the whole policy process. This new generation of policy theorists started to focus on explaining the ways in which: (1) institutions and institutional choice influence the likelihood of conflict and cooperation (Ostrom, 1999); (2) streams of problems, policy and politics come together to create windows of opportunity for actors to alter existing policy arrangements (Kingdon, 1994); (3) the nature of policy change as either gradual evolution or characterised by punctuated changes in long periods of stability (Baumgartner & Jones, 2009); and (4) the role of advocacy coalitions, beliefs and policy learning in the policy process (Sabatier & Jenkins-Smith, 1993).

When addressing (1) the institutional choice influencing the likelihood of conflict and cooperation, the *institutional analysis and development framework* examines the rules that individuals used to determine 'who' is included in decision situations; 'how' information is structured; 'what', and in 'what sequence', actions can be taken; and 'how' individual actions will be aggregated into collective decisions (Kiser & Ostrom, 1994,1982).

Within this model, policy is understood as sets of institutional arrangements comprising rules and norms that pattern the interactions and strategies of actors. Crawford and Ostrom (1995) explain

shared understandings of expected behaviour by a set of seven rules: (i) entry and exit rules governing who gets to use the resource in question; (ii) position rules indicating how actors can move from mere participation to performing a specialised task; (iii) scope rules referring to understanding of geographical or functional boundaries; (iv) authority rules indicating the degree of discretion that members are allowed; (v) aggregation rules indicating which decisions require consensus from other participants; (vi) information rules telling members which information should remain private and which must be made public; (vii) payoff rules denoting the sanctions involved for rule-breaking and incentives for rule adherence (Ostrom, 1999).

The strength of this framework is its capacity to identify the causal drivers of the policy process. These include the context in which local actors interact to create the institutional arrangements that shape their collective decisions and individual actions; explaining the different kinds of human behaviour influenced by different kinds of institutions and shared concepts in peoples' minds.

The main limitation of the framework is its assumption that individuals are self-serving and goal oriented in all situations and therefore actors make commitments based on incentives and sanctions. Also, the identification and measurement of institutions is more complex than set out in the framework. There is too little attention to the variables of the physical/material conditions and attributes of society that can be important to understand better why a policy process leads to different outcomes in different settings. Regime context can therefore be highly relevant for understanding the behaviour of individuals and, consequently, the achieved policy outcomes (Sabatier, 2006a).

The (2) *multiple streams framework* (Zahariadis, 1999; Kingdon, 1984) emphasises actors' central role in the process of transforming information into policy outcomes. Kingdon's (1984) multiple streams model of agenda-setting highlights three streams: (i) the problem stream; (ii) the policy stream; and (iii) the political stream. These move through the policy process independent of each other until a coupling of the streams occurs. The (i) problem stream identifies how individuals learned about the problems and the indicators that identify what become defined as problems. The (ii) policy stream includes a variety of proposals already in the system, generated by individuals specialising in a given policy arena. Kingdon argues that mutation and recombination of existing policies, rather than the generation of entirely new ones, drives the process by which new policy alternatives develop. Policies are selected according to criteria such as technical

feasibility, value consistency and acceptability in the larger political system but policy actions occur only when they fit the vision and values of the political climate (Exworthy & Powell, 2004; Wills & Woodhead, 2004; Exworthy et al., 2002; Kingdon, 1995). The (iii) political stream comprises the national mood; the balance of organised political forces (interest groups, political lobbyists, political elites) influencing policy; and the administrative or legislative turnover. Kingdon asserts that the convergence of the three streams opens a policy window opportunity for agenda-setting. Significant in this regard is Kingdon's definition of a policy window opportunity: "an opportunity for advocates of proposals to push their solutions, or to push attention to their special problems, [providing] opportunities for action of given initiatives" (Kingdon, 1995:120). This opportunity for the nursing profession to push for a new nursing act in Romania and Croatia depends, according to Kingdon (1994), on the agenda-setting capacity of the nursing leadership (i) understanding the EU accession process and the challenges identified through the Taiex mechanisms and processes. The (ii) policy stream refers to the diverging views and proposal on compliance with EU legislation, especially the Directive 2005/36/EC minimum criteria. Romania and Croatia do not have prior EU accession negotiations a nursing act setting out a process establishes the group norms of conduct and qualifications of the members belonging to the nursing profession. Within this policy stream it is interesting exploring the diverging views of nursing stakeholders on the compliance with Directive 2005/36/EC and as such mapping the acceptability of policy proposals and alternatives in the larger nursing profession community. Finally, when designing the study, Kingdon (iii) political stream could help focussing on the political feasibility of a policy ideas and proposals next to understanding the vision and views of the politicians in power with the mapping of the organised political forces and the power of the political elites influencing policy post Communism. The contribution of policy alternatives to the study relates mainly to focussing on the stakeholder engaged in the process of policy-making and mapping their conflicting views and alternatives when transforming information into policy outcomes. The (i) problem stream recognises the nursing education challenges as identified in the Taiex peer review reports while the (ii) policy stream includes two contrasting legislative proposals generated by the government (secondary level educational programme) and the proposal of the professional association moving the nursing education up to higher and even University level education. The (iii) political stream comprises the political mood to professionalise nursing and utilise the organised political forces to reach a policy consensus in compliance with the EU Directive 2005/36/EC.

The main limitation of Kingdon's approach is his assertion that each stream has a life of its own, with its own rules and dynamics; stream interaction occurs only during open windows. Mucciaroni (1992) argues that streams are more interdependent, with one stream triggering or reinforcing changes in another. Thus, the *Acquis* may open legislative and professional policy window opportunity by demonstrating that the previously unthinkable has become acceptable within a different context (Klein & Marmor, 2004). Nevertheless, Kingdon's agenda-setting theory does not respond adequately to multi-level governance by which important influence at international and European level is brought to bear upon a national political agenda-setting process (Underdal, 2012; Bruszt, 2008). Within the context of the study, it is interesting to explore whether a decision taken by means of a Directive at European level obliges MS to open a supranational policy window.

Michael Lipson's study of UN peacekeeping, *A Garbage Can Model of UN Peacekeeping,* illustrates the supranational weakness of Kingdon's model by demonstrating that it needs modification in order to fit multilateral settings (Lipson, 1997). Furthermore, Kingdon's policy-stream indicators need more attention as some hidden policy problems, such as the rivalry between individual leaders, occur outside the policy system. In order to have a chance of survival, Kingdon says that policy propositions must be compatible with the dominant values of members of the policy community, which needs further exploration. Furthermore, Kingdon does not explain how these dominant values emerge and can change or how alternatives previously unachievable at the political level can later gain popularity and acceptance. Similarly, the model does not make clear who selects the policy alternatives and at what stage of the policy process this takes place. A final main concern of Kingdon's multiple streams framework concerns its operation in a more incremental, adaptive approach (Mucciaroni, 1992). While Kingdon contends that agenda-setting is discontinuous and non-incremental, generation of policies can consist of patching and repairing, building on and learning from experience (Heclo, 1974). Many political scientists take issue with incrementalism, pointing out that it is not the way that policies *should be* developed. But it is perceived to be the option taken most frequently in reality.

Baumgartner and Jones's *punctuated-equilibrium theory* makes major improvements to existing policy theories and so occupies a prominent place in the policy literature (Baumgartner & Jones 2009; Jones et al., 1998). The main idea of this theory is that policy generally changes only incrementally due to the lack of institutional change and of individual decision-makers' flexibility

to respond to policy challenges. Consequently, policy is characterised by long periods of stability, punctuated by large (but rare) changes due to large shifts in public opinion, society or government. Hence, Baumgartner and Jones assert that institutional structures and agenda-setting processes are the foundations for understanding policy. Political conflict is at the centre of this theory as it stimulates debate on ideology and values.

The punctuated-equilibrium theory emphasises issue definition and agenda-setting as the dynamics of the policy process driving governmental policy decisions. The main limitation of the theory is that it was developed in a United States context and not many studies outside the United States (Busenberg, 2003) have tested the theory empirically.

In fact, this is a general concern as many policy theories have been developed within American and western European contexts of democracy. A further limitation of this theory arising from the literature review relates to the time required to understand how policy problems emerge and are debated, developed and implemented in order to understand the policy outcomes of policy decisions. Reflecting further on this limitation, the EU accession policy study is limited in time and is able to measure the achieved policy outcomes. Overall, experience of previous EU enlargements suggest that it takes around six to eight years to reveal how EU legislative compliance is achieved and how actors operate in the process to achieve policy change in compliance with EU legislation.

Finally, Sabatier takes a prominent position when analysing the continuum of policy theory, models and frameworks. The *advocacy coalition framework* developed by Sabatier and Jenkins-Smith (1993) explains policy change as a function of changes in: (i) the dominant governing coalition; (ii) events external to the policy subsystem; and (iii) policy-oriented learning that improves coalition understanding of successful political strategies and causal mechanisms affecting the policy problem.

This framework focuses mainly on the stakeholders engaged in the policy process, including actors from think tanks and interest groups, journalists, institutional and government leaders and policy researchers. According to Sabatier, policy-making occurs primarily among specialists within a policy subsystem and their behaviour is affected by factors in the broader political and socioeconomic system. Also, beliefs shared by a group of people (e.g. nurses) are more important than institutional norms and values. Nevertheless, the framework draws heavily on the individual

social psychology which is important in understanding the belief systems of the different policy-interest groups. In 1993 and 1999, Sabatier and Jenkins-Smith revised the original advocacy coalition framework to take account of its critical examination by several scholars (Heck, 2004; Cashore, 2003; John, 2003; Elliott & Schlaepfer, 2001; Dudley, et al., 2000; Sato, 1999; Howlett & Ramesh, 1998; Zafonte & Sabatier, 1998; Schlager & Blomquist, 1996; Capano, 1996; Schlager, 1995; Dowding, 1995; Jenkins-Smith & Sabatier, 1994; Weyant, 1988; Sabatier, 1987).

Although the main limitations of the model relate to the timeframe needed to study the complexity of coalitions of actors and their assessment of core values and belief systems, Sabatier and Weible (2006) recognised that it lacks clearly conceptualised and operationalised institutional variables that structure coalition formation and behaviour. There is also an important unanswered question concerning the network properties of subsystem participants and advocacy coalitions (Sabatier & Weible, 2006). Within the context of EU accession and nursing leadership, it is important to explore the coalition network properties and activities and evaluate how these properties impact policy outcomes. Reflecting further on the pitfalls of the advocacy coalition framework, Sabatier and Weible (2006) suggest that the need to explore the complexity of coalitions of actors and institutional variables gains importance when assessing actors' influence on the policy process. Most policy theories and frameworks focus on the actors and the individual but ignore the concept of engaging stakeholders in the policy process as they do not differentiate between actors and stakeholders (Boessen, 2008).

4.4 Engagement literature

WHO (2000:15) defines an actor as "any person interacting with others in the political system" and a stakeholder as "any party to a transaction which has particular interests in its outcome". The main difference is that actors influence policy directly by means of their political power but stakeholders influence policy indirectly as they lack the direct political influence required to make policy decisions. Julia Sieger (2009:166) defines a stakeholder as: "any representative organisation with a legitimate interest or mandate in the relevant area of policy-making providing input in the design, process and implementation of policies to their concern." Gabriel Almond and Sidney Verba (1989) describe civil society as the vital stakeholder in the policy process as civil society stakeholders make citizens better informed through their participation in politics and by

holding the actors, mainly governmental stakeholders, accountable for their decisions. Robert Putnam (1993) argues further that civil society is vital for democracy because it builds social capital and trust, and shares values transferred into the political sphere to hold society together. According to Putman, the strength of civil society lies in its awareness of community needs and potential as well as the ability to mobilise positive energy to find down-to-earth solutions.

Furthermore, the literature indicates that civil society consists of policy networks, representing clusters of stakeholders, with specific interests in a given policy sector. Marsh and Rhodes (1992) treat these policy networks as generic, with few stakeholders sharing basic values as a policy community (e.g. EFN) at one end of the continuum and issue networks at the other. In this way, many different and disparate groups and individuals are brought together for a common purpose or cause – the European Public Health Alliance, for example (Tantivess & Walt, 2008; Schneider, 2006; Thatcher, 1998). Nevertheless, stakeholders aiming to influence policy have to demonstrate their importance and profile if they are to be heard in the policy process (Young et al., 2010; McCown, 2009; Friedrich, 2006). Research findings suggest that the modes of interaction define the rules of stakeholder engagement and the setting in which stakeholders can represent their interests (Scharpf, 1997).

Thus, the engagement literature is important for further grounding the research design theoretically. A distinction is drawn between participation and engagement. Nicholson (2005b) refers to the relatively ineffective nature of participation in meetings, committees and focus groups as policy decisions remain the prerogative of the policy actors who may, or may not, take account of the views advanced by stakeholders through the numerous participation mechanisms. Instead, stakeholder engagement as a concept goes beyond participation because co-decision, a well-known EU political term, ensures that consensus must be achieved during the decision-making phase of the policy process (Fazi & Smith, 2006).

By contrast, engagement in the policy process creates space to build public understanding of a value-driven policy in which the policy analysis and design is influenced by the public interests at play and the trade-offs implicit in any governmental decision. When designing the study theoretically, it is important analysing the nursing leadership capacity to engage in the agenda setting process, not only towards existing institutional structure for credentialing, but equally towards political institutional structures negotiating EU accession. Engagement can provides

opportunities to improve the substance of policy input; cultivate trust between governments and the public; and increase the legitimacy of policy action and implementation. Both case studies, Romania and Croatia can be compared on these criteria: input, trust and legitimacy.

As such, engagement becomes closely linked to the form of governance within the political jurisdiction and refers to the way in which society determines how power, rights and responsibilities are used and distributed; and how it collectively solves problems and prioritises and reconciles its economic, social and environmental objectives through the policy process (Kickert, 1997; Rhodes, 1997; Scharpf, 1997).

Conversely, and in contrast to Wildavsky's views, Bonney (2003) suggests that those interested in policy-making need to focus on those mechanisms designed for individuals rather than collective groups. Bonney argues that organised interests dominate the policy process with the risk of preserving "the status quo rather than producing major change" (Bonney, 2003: 466).

4.5 Leadership literature

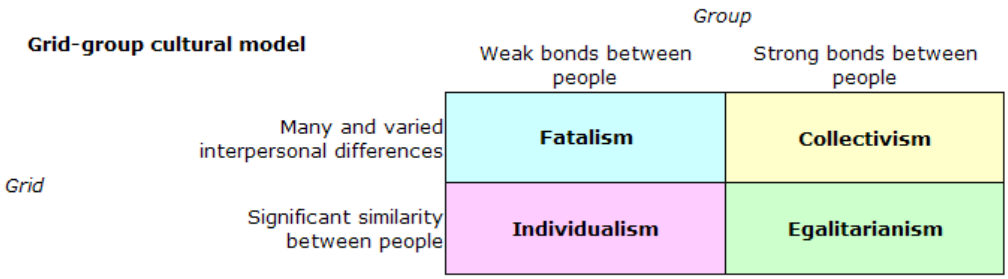
The literature review builds further on stakeholder engagement by examining the leadership literature. Aaron Wildavsky's *Cultural Theory of Leadership* draws attention as he argues that an individual's political attitudes are determined more by the political culture (regime) than by any other factor, including their race or gender, socioeconomic status or even their political understanding and party affiliations (Gastil: 2005; Wildavsky, 1987). He also argues that – as long as the emphasis is on the individual and his/her skills, and not on the regime under which the action takes place – variety will always overcome commonality. Interestingly, Wildavsky sees leadership in the policy process as a function, or consequence, of political culture (regime).

Therefore, it is essential to understand leadership in a changing regime in order to understand "why we get the kind of policy, what kind of policy we want, and what we have to give up in order getting it" (Wildavsky 1987:166). It is therefore important when designing the study to challenge Wildavsky excessive importance to regime over other factors and be alert to inputs from different contextual variables impacting on policy outcomes.

Although Wildavsky succeeded in putting macro-politics back into micro-leadership, Wildavsky leadership theory is based on types of regimes connected to types of leadership based on the

number of prescriptions within the regime and the group strength. Based on two criteria of the way of life (grid and group) Wildavsky developed four basic models of culture in which four leadership styles are allocated: (i) collectivism and positional leadership; (ii) communitarianism (charismatic leadership); (iii) individualism (meteoric leadership); and (iv) authoritarianism (despotic leadership).

Figure 1: Wildavsky's cultural theory



Source: Wildavsky, 1987.

Wildavsky believes that people in an individualistic (market) culture are relatively similar, have little obligation to one another, regulate their relations by few rules and become connected through networks and deploy meteoric leadership with everyone being responsible for their own results and no-one but the individual is to blame if he/she fails. In contrast, a collectivist (positional, hierarchical) culture deploys according to Wildavsky a positional leadership style with members of a community being strongly connected.

When positioning the research study theoretically, it is important to acknowledge that some analysts see political culture in virtually everything touching political life; others view regime merely as a residual category that explains what remains unexplainable by other means. Elkins and Simeon (1979) and Laitin (1995) raised questions about the precision and predictive power of political culture, and other scholars (DiPalma, 1990; Schmitter et al., 1986) even question whether culture plays any role. However, culture is history's principal contemporary expression but the allocation of specific leadership styles is less evident in explaining policy outcomes. Thus, it is important that the study design explores how identity impacts on the patterns influencing the EU accession policy process, aiding better understanding of the interests driving the nursing leadership's strategic influence on the policy process. This is an essential part of the study design

as the review of the leadership literature indicates that sociologists and psychologists have developed many theoretical models of leadership, as summarised by David Boje (2005) – a universal trait approach (1800s–1940s, revival in 1990s) moves towards a behavioural approach (1940s–1970s, revival in 2001) that is followed by the situational and contingency approach (early 1960s to present).

A variety of terms are used to describe leadership, including – transformational and transactional leadership (Kelloway, 2000; Avolio, 1999; Bass, 1985; Burns, 1978); charismatic leadership (Conger, 2003, 1988; Bryman, 1992); formal and informal leadership (Heifetz, 1996); visionary leadership (Westlay, 1989); political leadership (Burns, 1978); and, simply, leadership.

Interestingly, House (1997) argues that leadership theories and models do not facilitate a better understanding of policy-making although his path–goal theory of leader effectiveness, classified as a transaction leadership theory, focusses on the leader's behavior being contingent to the satisfaction, motivation and performance of those following the leader. This could imply, when locating the study theoretically, that effective nursing leader's should clarify and reduce pitfalls for the nursing profession to achieve policy goals. This also implies that individual leadership differences may explain substantial variance in policy outcomes. This contrasts with Wildavsky's view that most leadership theories and models place too much emphasis on the individual, at the expense of the collective leadership capacity and the context in which leadership is exercised. Therefore, it is worth noting John Maxwell's assertion that: "leadership is influence … more, if not much more, influence than position.

Although Maxwell (2007:78) argues that "being in a position in an organisation does not guarantee that you are influential", it is interesting exploring the individual leadership capacity of the four nursing leaders – the chief nursing officer at the Ministry of Health, the nursing regulator leader, the nursing professional association president and the head of the nursing union – possibly negotiating with policy-makers and politicians the design of a nursing act in compliance with the Directive 2005/36/EC.

Therefore, to advance the leadership theory, the research design incorporated the analysis of 'nursing leadership to influence the EU accession policy processes by which two former Communist-regime countries joined the EU, Romania in 2007 and Croatia in 2013. The current research study can enrich the knowledge on leadership by exploring the engagement of

stakeholders in the EU accession policy process and the legislative and professional outcomes achieved when entering the EU. Therefore, to advance the leadership and policy-making research agenda, it is important that the study design takes account of the concept of the nursing leadership's advocacy and lobbying in the policy process.

4.6 Advocacy literature

The word 'advocacy' is frequently found in discussions, definitions and descriptions of lobbying. To differentiate between lobbying and advocacy, Ezell (2001) considers lobbying one of many advocacy tactics that seek to make a difference. As an accepted and legal process, lobbying allows the voices of citizen groups, associations, labour unions, corporations and others to be heard in the political arena. Heath and Cousino (1990) describe lobbying as a function of management; Toth (1986) recognises it as a specialised area of public relations; and Cutlip, Center and Broom (2000) define it as a function of public affairs that builds and maintains relations with government primarily for the propose of influencing legislation and regulation. Arroyo et al. (2002) define lobbying as the deliberate attempt to influence political decisions through various forms of advocacy directed at policy-makers on behalf of another person, organisation or group. Koepl (2000) defines lobbying as the attempted or successful influence on legislative-administrative decisions taken by public authorities through intended and targeted actions.

Guth and Marsh (2000) suggest that lobbyists pass on persuasive information to government officials and Dondero and Lunch (2005) assert that lobbyists perform three primary functions in the legislative arena: (i) disseminate information needed for crafting legislation to legislators and their staff; (ii) aggregate public opinion around major issues affecting their clients; and (iii) help set the political agenda by creating coalitions to support or oppose specific legislative designs. Whatever the definition of lobbying and the activities linked to it, lobbying involves attempts to influence the political and legislative system (Zorack, 1990).

Similar to lobbying, the concept of advocacy embraces many definitions in the literature. Ezell (2001) defines advocacy as purposive efforts to change specifically existing and/or purposed policies or practices on behalf of, or with, a specific client or group of clients. Edgett (2002) defines advocacy as the act of publicly representing an individual, organisation or idea with the object of

persuading targeted audiences to look favourably on – or accept the point of view of – the individual, the organisation or the idea. Thus, advocacy is a central function of lobbying.

In the literature, advocacy becomes also defined as a process whereby stakeholders at different levels raise issues of concern, participate in decision-making, hold decision-makers accountable for their actions and work for resolutions to their problems through changes in policy, laws, regulations or practices (Prakash & Gugerty, 2010; Baumgartner et al., 2009).

Consequently, advocacy activities are systematic efforts by groups to further specific policy goals. These policy goals translate into the retention of an existing policy or a policy change. This definition is a middle way between very broad definitions ranging from Jordan & van Tuijl's (2000) assertion that implementation work is advocacy to others that focus much more narrowly on direct interactions with decision-makers.

Although definitions provide an important guidance to the research design, the social science dependent/independent models used in public policy and human services delivery is found unable to probe the complexity of the policy-making process and the role of interest groups in it (Reisman et al., 2007a; Guthrie, et al., 2005). Therefore, the literature indicates that evaluation research offers reliable tools and processes to evaluate the advocacy actions and provide the basis for re-thinking strategies and tactics (Reisman et al., 2007a). Recent advocacy articles have focused on the need to consider the policy context and theories of policy change.

The advocacy literature make explicit reference to John Kingdon's influential model of 'policy windows' as an explanation of the agenda-setting stage of policy-making (Coffman, 2007b). Nevertheless, researchers look at how advocacy is contributing to the advancement of Kingdon three policy streams – problems, proposals, politics – in order to create a 'policy window', while at the same time potentially providing scope for the evaluation to discuss external factors that are either supportive of or undermining the advocacy efforts.

When designing the study, addressing the nursing leadership advocacy capacity to influence the EU accession process is central to evaluate the Commission's mechanism to bring national legislation in line with European legislation.

In the context of national political systems, the central elements that affect expectations of success or failure are identified in the literature as: having institutional access, political alignments, knowing influential allies, divided allies and prospects of facilitation or repression of contentious politics (Tarrow, 1998; McAdam, 1996). More recently, the concept has been expanded to include discursive opportunities (Ferree et al., 2002). Therefore, it could be interesting to consider three dimensions within the study design: (i) nursing leaders' access to the EU accession policy process; (ii) influential allies and adversaries for advancing the nursing agenda; and (iii) limited repression and facilitation. Access determines the degree to which a lobby space is open or closed to the nursing leaders and whether, and how easily, they can enter the political and policy environment of the EU accession.

Influential allies and adversaries can shift the power balance and are described in the literature as crucial for any group involved in advocacy. Finally, limited repression and facilitation refers to the activities that governments and governmental agencies undertake to restrain or foster the political engagement of interest groups in the policy process. It is important that the research study determines whether the nursing leadership is engaged in policy design to comply with EU legislation and, if so, how they engaged in this policy process, when they engage prior to EU accession and whether this results in successful policy and professional outcomes.

4.7 Summary

This chapter has considered the relevance and applicability of the Europeanisation, policy, engagement, leadership and advocacy literature to design the study. The review of this tranche of literature has been useful to better understand the complexity of the policy-making process; the strengths and limitations providing the rationale for designing the study theoretically.

The first point relevant for the study design is the need to focus on EU accession as being part of Europeanisation and explore the influence of the nursing leadership on the EU accession policy and professional outcomes and consequently evaluate the pre-EU accession dynamics on post-EU accession legislative and professional developments. Therefore, the study design also needs to take account of how domestic change is processed and the patterns of adaptation, specifically for the nursing profession in Romania and Croatia.

Both study cases were exposed to different models of Soviet-style socialism that imposed political, social and economic homogeneity between the late 1940s and 1989, therefore the study design needs to be sensitive to the impact of regime and the interaction between state and non-state stakeholders in the formulation of domestic politics and policy-making. It is important to understand the achieved legislative and professional outcomes as a discourse which stakeholders used to make sense of reality.

Secondly, most scholars have focused on the exploration of policy theories within a democratic system, mainly in the United States and Western Europe. Therefore, the study design incorporated no specific option for any theory or model at the start of the study although some models – e.g. Kingdon's (1984) multiple streams model (problem, policy and political) and Wildavsky's cultural theory (four types of regimes and leadership) – were likely to be more appropriate for presenting the study findings more systematically.

Instead, the study design aims at advancing the knowledge base on nursing leadership within an enlarging EU based on incorporating the impact of regime-specific contextual conditions on the nursing leadership advocacy capacity, the engagement of the nursing leadership in the EU accession policy-making process and the degree by which a Directive at European level obliges acceding countries to open a supranational policy window. Examination of the nursing leadership engaged in the national policy design to comply with EU legislation should allow better understanding of how and when these leaderships engage and whether their advocacy has resulted in successful policy outcomes for the nursing profession in both case studies. It is essential to understand leadership in a changing regime in order to understand why we get the kind of policy outcome, what kind of policy outcome we want, and what we have to give up in order to get it.

Finally, when positioning the research study theoretically, it is important to focus upon the concept of stakeholders' engagement in the policy process as most policy and leadership theories and models emphasise the individual, at the expense of the collective leadership capacity. The engagement literature was therefore helpful to orient the study design towards mapping the role and impact of stakeholders, with specific interests in a given policy sector (nursing education and free movement). Although the literature review suggested that the modes of interaction between stakeholders defined the rules of stakeholder engagement and the setting in which stakeholders

represent their interests, the study incorporates in its design the nursing leadership capacity in consensus building (TAIEX) during the pre-accession policy process to improve the substance of policy input in addition to cultivating trust between the government negotiating EU accession and nursing profession leadership. The study design therefore includes the idea of multilevel governance as a system involving institutions, stakeholders and processes in Europeanisation through pre- and post EU accession.

Chapter 5 Research design

This chapter presents a critical discussion of the development, implementation and limitations of the plan of investigation, beginning with the research question, aim and objectives. These were informed by my position and the literature reviewed. Central to this chapter are the reasons for adopting a qualitative methodology and employing a comparative case study using an ethnographic approach as the chosen research design. Case selection is described in detail before moving onto addressing the data collection methods, procedures and the data analysis. Before setting out the ethical considerations, attention is given to fieldwork – considering my positionality, interviewing political elites and use of interpreters. The chapter concludes with a critical reflection on the robustness of the study.

5.1 Research question, aim and objectives

Having set out my position and the formulation of a concise research question, consistent research aim and focused objectives, the research began with the identification of the knowledge gap in the Europeanisation, policy, engagement, leadership and advocacy literature (chapter 4). As described in chapter 2, the EU accession process consists of negotiations between national government and the European Commission with the aim of aligning national legislation with the European Directives from the *Acquis Communautaire*, comprising 35 negotiation chapters detailing requirements for EU accession that European institutions sign off when the candidate country has passed appropriate national legislation or taken necessary actions. One chapter in the *Acquis* concerns the implementation process of the Sectoral Directive on Mutual Recognition of Professional Qualifications (Directive 2005/36/EC). This is the main focus of the thesis, with the research specifically examining the nursing leadership's engagement in the design of a national nursing act in compliance with the Directive 2005/36/EC.

The research question addressed is:

> *To what extent did the EU accession process provide an opportunity for the nursing leadership in Romania and Croatia to advance a professional agenda at national level?*

This question was explored using Romania and Croatia as examples. More specifically, the study set out to investigate the extent to which nursing leaders in both cases used the EU accession

process to formulate and implement a professional agenda and achieve policy goals. Four specific objectives underlie the study.

Objective 1: *To identify the context and conditions which have helped or hindered nursing leaders to engage with the EU accession process.*

Objective 2: *To explore the processes and mechanisms through which nursing leaders have engaged specifically with the Acquis Communautaire in the case-study countries.*

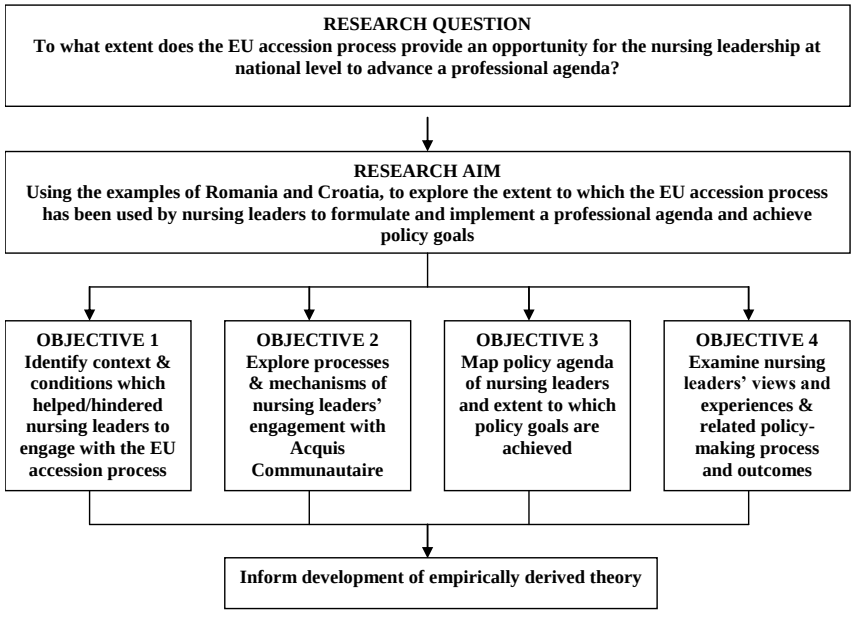
Objective 3: *To map out the policy agenda of nursing leaders and the extent to which policy goals have been achieved in the case-study countries.*

Objective 4: *To examine nursing leaders' views and experiences of the EU accession process and the related policy-making process and outcomes at national level.*

These objectives are expected to inform the development of an empirically derived theory of policy-making in the particular context of an enlarging EU. In particular, the research explores the extent to which western European policy-making theories – which make up the majority of the available literature – are appropriate for a central and east European context as exemplified by Romania and Croatia.

The links between the research question, aim and objectives are summarised in Figure 2

Figure 2: Links between the research question, aim and objectives



5.2 Research methodology and design

The thesis adopts a qualitative stance and employs a comparative case study fusing an ethnographic approach. These were chosen following consideration of the ideas and concepts of several leading authors in the field, including Holliday (2007) and Denzin (2008) on qualitative research; Slembrouck (2005) and Sultana (2007) on reflexivity; Flyvbjerg (2006) on case-study research; Brown and Dobrin (2004) on ethnography; and Eisenhardt and Graebner (2007) on theory building. The key considerations for the particular choice of a comparative case study with an ethnographic approach included the nature of the research question, aim and objectives, exploration of underlying meanings, the importance of reflexivity and the capacity for new knowledge development.

5.2.1 Nature of research question, aim and objectives

The nature of the research question, aim and objectives were the main consideration behind the choice of methodology and research design (Collier, 2005; Lee et al., 1999; Creswell, 1998; Yin, 1994). The research question and objectives posed were very much how and why questions – *how* things happened and *why* nursing leaders engaging in the policy process acted as they did (Green & Thorogood, 2004).

A qualitative approach is best suited to investigating the EU accession policy process because it allows exploration that explains the events and decision-making involved. Such an exploratory approach was particularly useful because little is known about how and why nursing leaders and policy-makers in former Communist-regime countries engage in policy-making prior to joining the EU.

In particular, a cross-national comparison offered the opportunity to conduct an in-depth examination of policy-making (Amenta, 1991) allowing greater precision of meaning to be given to context (Merriam, 2002a, 2002b; Nassar, 2001; Hoepfl, 1997; Bradshaw & Wallace, 1991). Moreover, an in-depth comparative case study approach was best suited to exploring the impact of historical context (Bradshaw & Wallace, 1991) and the general complexity of social and political influences (Beetham et al., 2003; Yin, 1994; Feagin et al., 1991; Stoecker, 1991; Eisenhart, 1989) on the actors and policy-making processes under study (Eisner, 1991; Lee et al., 1999; Nasser, 2001; Merriam, 2002b).

Cross-national variations can shed light on what has and has not worked; therefore comparison of even two cases can provide a better understanding of the progress made in each country's situation (Ebbinghaus, 2005; Verma & Mallick, 1999; Creswell, 1994). Ebbinghaus (2005) and Lor (2011) focus on single country studies being very intensive and conducted in considerable detail, while the more countries selected, the less intensively each one will be studied (Landman, 2008:26). Nevertheless, Landman (2008) argues that using qualitative methods in analysis of many-country comparisons is unusual because "a richer level of information" is needed, including "deep history", which would be difficult to collect and analyse if large numbers of countries are involved (Landman 2008:52). Only in the case of hypothesis testing (not our case), a relationship holds between the number of variables tested and the number of cases involved in the comparison: the more variables that may exert a potential influence on the phenomenon under investigation, the more cases are needed to test all the possible combinations of several variables (Lot, 2011). In terms of the number of cases being compared, few-country comparisons can be as few as two. Two or three appear to be the most prevalent number in comparative studies. The deciding factor, however, is not so much the number of countries, but the methodological approach.

The ethnographic approach to the comparative case study (Babbie, 2001; Cohen et al., 2001; Merriam, 1998) enabled better understanding and exploration of the ways in which nursing leaders and policy-makers in Romania and Croatia created, modified and attached meaning to their experiences of the policy-making process during the Communist regimes (in which they grew up) and perceived the EU enlargement and policy accession negotiations. As the strategic behaviour of nursing leaders and policy-makers and their efforts to influence policy are not unique to any country or to any policy area (Wildavsky, 1987), an ethnographic approach is most appropriate as research objectives one (*the context and conditions which helped or hindered nursing leaders to engage)* and four (*views and experiences of the EU accession process and the related policy-making process and outcomes)* relate to the meaning participants assigned to their experiences.

Finally, to achieve the research objectives, it was important to gain in-depth understanding from the perspective of particular social (as in nursing) and cultural (as in Romania, Croatia) groups of people.

Thus, applying an ethnographic approach to explore the policy-making process (Flick, 2007, 2002; Travers, 2001), especially in the health sector (Keen & Packwood, 1995; DePoy & Gitlin, 1994), provided an opportunity for detailed examination of the policy process and its implementation (Exworthy et al., 2002) while maintaining a focus on the possible influence of culture (regime).

5.2.2 Exploring underlying meanings

More than any other methodology, a qualitative approach has the potential to reveal the texture of settings; the natural language of those living in those settings; and the network of relationships that exists (Ragin et al., 2004; Long et al., 2000). When moving beyond the superficial, differences can emerge as interviewees have different emotions in different situations and may define the success of the development of nursing and legislation differently. Participants may have different expectations based on different motives for engaging in EU accession, so it is important to capture differing perspectives. By contrasting the two cases under investigation, distinctive differences and similarities concerning what the EU legislation means for interviewees can emerge, particularly as Romania and Croatia have different starting points for entering the EU (respectively 2007 and 2013). Consequently, there may be distinctive challenges for the nursing leadership engaging in negotiating compliance with the EU political institutions, European Commission, European Parliament and the Council of Ministers.

Therefore, the concept of difference was central to the research question and the methodology chosen. Such a focus can highlight participants' differentiation by gender, age, life-cycle positioning, race, ethnicity, class, marital status and other axes of difference (Parpart, 1995; Mbilinyi, 1992). An ethnographic approach has the potential to give meaning to differences and similarities and to explore how these influenced the nursing leadership in the policy-making process and the achieved legislative and professional outcomes. Therefore, a qualitative comparative case study was best suited to distil these similarities and differences as it permitted comparison and contrast of cases that possess common and extreme characteristics. Indeed, within this comparison, the study has the potential to explore the varying meanings of concepts in different national contexts (Phondej et al., 2011).

Furthermore, an ethnographic approach to the comparative case study has the potential to sharpen these distinctions as it requires more comprehensive and closer contact with the

participants. Patterns of participants' shared and contrasting meanings and perceptions across cases are not easily quantifiable (Fraenkel & Wallen, 2006) and can be achieved only by developing an intimate familiarity with the dilemmas, frustrations, routines, relationships and risks that form part of the participants' everyday lives (Grills, 1998b). In other words, the study needed to explore the beliefs and ideas, similarities and differences in participants' views on the EU policy-making process and the actions taken by nursing leaders when setting the policy agenda and influencing the process of nursing legislation development in compliance with the European Directive 2005/36/EC (Maxwell, 2008; Hammersley & Atkinson, 2007; Merriam, 2002b; Nasser, 2001; Lee et al., 1999; Hoepfl, 1997; Eisner, 1991). Hence, the chosen study design was designed to meet the goals of exploring diversity, interpreting historical significance and advancing theory (Ragin, 2004). Furthermore, the chosen case study design following an ethnographic approach was well-suited to capturing interviewees' range of views on the way that the nursing leadership influenced the process of policy-making, which may itself have been influenced by the context in which participants grew to maturity during the USSR's Communist regime (Exworthy et al, 2011; Hammersley & Atkinson, 2007; Silverman, 2000).

5.2.3 Reflexivity

Being attentive to the politics of knowledge production has gained importance in the literature (Caitlin, 2007; Falconer Al-Hindi & Kawabata, 2002; Moss, 2002; Hurd, 1998; Jones et al., 1997; England, 1994; Katz, 1994). Consideration of my professional status, of my position as an insider or an outsider and its impact on the research design has the potential to enable more nuanced understandings of the research findings.

Reflexivity requires an awareness of my contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining entirely outside the study (Sherman & Webb, 1988). Reflexivity prompted me to explore the ways in which my own professional values, experiences, interests, beliefs, political commitments, wider aims in life and social identities shaped the research design (Nightingale & Cromby, 1999; Hammersley, 1992).

The inquiry and the methods employed were inextricably bound up with the politics of practice (Gupta & Ferguson, 1997) and informed by my own subjectivities. My professional status not only affected the research aim and objectives but also made the research a political and personal

process for change. The ethnographic approach had the potential to allow me to take account of my subjectivities and positionality (Peake & Trotz, 1999) and to enable me to play an important role in “the positive development of reflexive forms of theorising, allowing some kind of a voice to those who live their conditions of existence” (Willis & Trondman, 2000:7). Furthermore, reflecting on the duality of positionality helped design a more meaningful qualitative research process (Falconer Al-Hindi & Kawabata, 2002; Slembrouck, 2005).

5.2.4 New Knowledge Development

When addressing the essential question of what constitutes legitimate knowledge (Hammersley & Atkinson, 2007; Savage, 2000; Fielding, 1993; Stanley & Wise, 1993), the literature of Seale (2004) and Flyvbjerg (2006) was extremely helpful in counterbalancing the most pertinent misunderstanding that: “general, theoretical, context-independent knowledge is more valuable than concrete, practical, context dependent knowledge” (Flyvjerg, 2006:391). Flyvbjerg (2006) argues that concrete, context-dependent knowledge is more valuable to the contribution of scientific knowledge and that “formal generalisation is overvalued as a source of scientific development, whereas 'the force of examples' is underestimated” (Flyvbjerg, 2006:394). Therefore, the main scientific challenge was to search with a reasonable degree of confidence for new empirical knowledge in the field of EU accession and enlargement (Murphy et al., 1998; Hammersley, 1992). Consequently, a qualitative approach was appropriate for developing new knowledge related to the policy window offered by EU accession. By using the appropriate study design and methods, the research ambition was to generate data and where possible discover new knowledge that makes sense of the qualitative data generated from the policy context in which the nursing leadership operates in policy-making for EU compliance. It is therefore argued that an ethnographic approach is equally as good, or better, for building explanations as the discoveries and comparison of participants’ visions and beliefs (formed by where they live out their lives) entails proximity to reality (Klein, 1991). Equally important, a comparative case study using an ethnographic approach can generate a learning process constituting “a prerequisite for advanced understanding by casting off preconceived notions with the ultimate aim of achieving new insight” (Flyvbjerg, 2006:399).

Finally, it needs to be clear that the study has no ambition to generalise beyond the cases as there is general agreement that the main purpose of qualitative research is to derive, through induction, a holistic understanding (of nursing leadership impact on policy-making, in this case) rather than discovering, through deduction, universal generalisable truths (Hammersley & Atkinson, 2007; Savage, 2000; Fielding, 1993; Stanley & Wise, 1993). Personal narratives are particularly useful in unsettling generalisations, subverting the process of 'othering' (Abu Lughod, 1993) and raising questions about the how, why and what meaning that people give to their experiences and actions. Furthermore, personal narratives can challenge existing theoretical views that are often detached from the complex and multiple realities of participants (Mies, 1991; Kirby & McKenna, 1989). Giving participants the opportunity to tell their stories enabled them to reproduce their own images of themselves and their relations with others. This type of qualitative data is often ignored in EU health and accession policy research on the basis that it is too individual, too specific and atypical. But it is this very specificity and concreteness which gives the strength to challenge long-standing theoretical generalisations (Moore & Vaughan, 1994).

5.3 Case study selection

Case selection represents an important aspect of new knowledge development (Caramani, 2008; Eisenhardt & Graebner 2007; Neergaard & Ulhøi, 2007) and, as the comparative case study uses a small number of cases (Ebbinghaus, 2005), it was important to select the cases carefully. The study design did not follow a `theoretical' sampling designed to generate theory `grounded' in the data. In contrast, the selection is established in advance of the fieldwork (Glaser and Strauss, 1967; Strauss and Corbin, 1990) following a `purposive' sampling suitable for qualitative research (Patton, 1990).

In order to reduce selection bias (Odell, 2001), the criteria for selecting the cases were justified in relation to their relevance for answering the research question (Adler & Barnett, 1998; Finnemore, 1996b; Katzenstein, 1996a; Stake, 1995; Yin, 1994; Lee, 1991; Eisenhardt, 1989). The main criteria for selecting Romania and Croatia relate to their historical and political contexts, their different positions within the EU accession process – especially timing and the stage reached in the overall accession process at the time of the study – and the different levels of development of their nursing professions (Table 1).

5.3.1 Cases should provide ostensibly different contexts for policy-making (Table 1 and Table 2)

At the beginning of the 1990s, both Romania and Croatia were far from achieving the prerequisites for EU accession – stability of national institutions guaranteeing democracy, the rule of law, human rights and the transformation to a functioning single market economy (MacLehose & McKee, 2002). Hence, both cases provide an opportunity to explore the extent to which the nursing leaderships engaged in advocating change, democracy and stability in the Balkan region.

Furthermore, an important part of the research enquiry concerned how nursing leaders were formed during the former Communist regime, contrasting the cases to explore how similarities and differences in policy-making can be achieved. Prior to 1990, both cases were embedded in Communism but experienced Communism differently. Romanian nursing leaders and policy-makers negotiating the *Acquis* had all experienced the Ceausescu regime and perceived it as one of the harshest and most nationalistic of the Communist dictatorships (Bideleux & Jeffries, 2007; Crowder, 2007; Goldfarb, 2006; Kupiszewski et al., 1997; Linz & Stepan, 1996; Hitchins, 1996; Verdery, 1996; Gallagher, 1995; Berinde, 1994; Barnett, 1992; Ronnas, 1991; Bachman, 1989); Croatian nursing leaders and policy-makers experienced a more liberal Titoist Communism (Djilas, 2007; Arfi, 2005; Živanov, 2001). The different context of the Communist regime is important for exploring the views and experiences of participants, in addition to the mechanisms for policy-making and the evaluation of policy outcomes after accession to the EU. Although both cases moved from a totalitarian regime to democracy, and both political revolutions took place in 1990, their experiences were different – Romania moved towards a bicameral parliamentary system in 1991; Croatia implemented a unicameral parliamentary system in 1996 after the third Balkan War. These differences impacted on the negotiations for EU accession (Wildavsky, 1987).

Unlike others in eastern and central Europe towards the end of the 20th century, Romania's political revolution was violent, ending with the execution of Nicolae and Elena Ceausescu on 25 December 1989 (Goldfarb, 2006). However, except for the ten-week military confrontation in 1999 between NATO and Serbia over Belgrade's maltreatment of the Albanian population of Kosovo, Romanian nursing leaders and policy-makers were not exposed to the Balkan war (1991-1996). In contrast, Croatian nursing leaders and policy-makers faced the consequences of the ethnic Balkan War (Voncina et al., 2006).

5.3.2 EU accession (Table 1)

The criteria for selecting Romania and Croatia relate to the different position and especially timing and the stage reached in the overall accession process at the time of the conceptualisation of the study (2005), next to their diverging historical and political context post Communism and pre EU accession negotiation plan.

When designing the study in 2005, ten countries from central and Eastern Europe and the Mediterranean just joined the EU in 2004 and as such became rejected for inclusion. Although the fifth wave preparations for enlargement included Romania and Bulgaria and the sixth included Croatia, planning to join the EU in 2007, Bulgaria was rejected for inclusion as my engagement in the EU accession capacity building (positionality) focussed only on Romania and Croatia. Opting to include Bulgaria instead of Romania, or opting for the three cases, would create inequalities for access and assess the EU's accession conditionality related to Directive 2005/36/EC. As the thesis aims is to advance knowledge on the potentials and limits of the EU's leverage on aspiring and would-be members and provide insights into the domestic conditions for its success, it is important the researcher's positionality for both cases is the same. This is the main reason why other countries, such as candidate (e.g. Turkey, Iceland, Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro, Serbia) and potential candidates (e.g. Serbia, Moldova, Ukraine and Georgia) were rejected for inclusion.

Romania submitted a formal application for EU membership in June 1995. In December 1997, the Luxembourg European Council set February 2000 as the official start date for membership negotiations. The Copenhagen Summit in December 2002 set 2007 as a target joining date and Romania signed the accession treaty in April 2005, with 1 January 2007 as an entry date. In contrast, Croatia has just joined the EU (July 2013). Due to the Balkan War, Croatia did not submit a formal application for EU membership until February 2003. The Council of Ministers granted Croatia official candidate status in June 2004 and the European Commission and European Parliament agreed to start accession negotiations with Croatia in October 2005. However, these were delayed by Croatia's failure to co-operate fully with the UN war crimes tribunal in The Hague. Thus, the target date for Croatia's accession became postponed to 1st July 2013. In view of these differing experiences, the extent to which the nursing leadership has used EU accession process to formulate and implement a professional agenda and achieve nursing policy goals represents an interesting area for exploration.

Despite the different positions of Romania and Croatia, both are of high political interest to the EU. Prior to EU accession, most western European MS considered Romania's political influence in the south-east and central Europe important, making Romania a gatekeeper for the EU in the ongoing enlargement and Europeanisation process, especially for Moldova, Ukraine, Belarus, Armenia, Azerbaijan and Georgia (Figure 3). Similarly, Croatia has played a central role in the future accession of the Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro, Serbia and Kosovo (Figure 4).

Figure 3: Map of Romania and its neighbours

(Source: http://atlas.mapzones.com/romania/romania.php)

Figure 4: Map of Croatia and its neighbours

(Source: http://atlas.mapzones.com/croatia/croatia.php)

It is in the EU's strategic interest to have stable, democratic and increasingly prosperous neighbours in the western Balkans. The Romanian and Croatian accession negotiations were therefore important steps towards prosperity for the whole Balkan region as they constituted a signal of encouragement to other countries in the region.

5.3.3 State-of-the-art of the nursing profession (Table 1)

The political transition in the early 1990s led to a mass of health system decrees and regulations in both Romania and Croatia (Busse & Dolea, 2001). Despite reforms passed by their respective parliaments, there have been ongoing problems with implementing change in practice. This is especially true for the nursing profession and is due, in part, to the lack of a clear strategy and objectives (Busse & Dolea, 2001). Romania and Croatia both share the legacy of a Soviet-influenced health-care system, based on the hospital-focused Soviet Semashko model mainly based on informal payments (Gaal and McKee, 2004; Rechel et al., 2004; Ho & Ali-Zade, 2001). Moreover, the nursing profession is in quite similar conditions as old mentalities persisting from the post-communist conservative regime have ensured that nursing education continues at a lower level than that of the medical profession.

However, Romania and Croatia face different challenges in adapting policy structures to meet the *Acquis* criteria, implementing minimum EU standards related to the content and duration of nursing education and moving from a secondary level to a higher or university level education for nurses. Equally, it is expected that they will have differences in their perceptions of EU agenda-setting and in the political will to implement the EU nursing legislation. Both countries have worked to different timescales in preparing the legislative framework for implementing Directive 36. Croatia began preparations for a Nursing Act in 2000 and obtained national parliament approval in 2005 but the accession negotiations need to evaluate this newly developed national nursing legislation against the European Nursing Directive. The first Romanian Nursing Act was developed in 2001, reviewed in 2003 and approved by the Romanian national parliament in 2004. Romanian national legislation for nursing was negotiated between 2004 and 2006, enabling closure of Chapter 3 of the *Acquis* and leading to Romania joining the EU in January 2007.

Table 1: Main selection criteria

Criteria	Sub-criteria	Romania	Croatia
Historical policy-making context	*Regime*	1960–1989: Ceausescu regime – harshest and most nationalistic of the communist dictatorships; dragged Romanians into political, economic, social and moral deadlock; ended in violent revolt.	1955–1980: Tito regime – more liberal approach in policy-making but since 1970s most conservative section of Communist Party – with old ideological and political beliefs – has held balance of power.
	Political context	1991: moved from unicameral to bicameral parliamentary system with seven political parties. Similar configuration to European Parliament.	1996: moved from bicameral to unicameral parliamentary system, consisting of 41 political parties and 8 coalitions.
	War	1999: ten-week military confrontation between NATO and Serbia over Belgrade's maltreatment of the Albanian population of Kosovo.	1991–1996: Balkan War – ethnic conflict in which up to 20 000 people were killed or reported missing and more than 30 000 were disabled.

EU accession	*Date of accession*	June 1995: formal application for EU membership. December 1997: Luxembourg European Council decision. February 2000: official start of EU membership negotiations. December 2002: Copenhagen Summit set 2007 as target date for joining EU. April 2005: Romania signed accession treaty giving 1 January 2007 as EU entry date.	February 2003: formal application for EU membership. April 2003: Council of Ministers requests opinion of European Commission (provided April 2004). June 2004: official candidate status. March 2005: negotiations delayed by Zagreb's failure to co-operate fully with the UN war crimes tribunal in The Hague. October 2005: European Commission and Parliament agreed to start negotiations for accession in 2006, setting 2010 target date for EU accession.
	EU political interest	Romania's political culture moved from destabilising influence to become important strategic gatekeeper. Important for future EU accession of Moldova, Ukraine, Belarus, Armenia, Azerbaijan and Georgia.	Plays central role in future EU accession of Former Yugoslav Republic of Macedonia, Albania, Bosnia and Herzegovina, Montenegro and Serbia including Kosovo.

State-of-the-art of the nursing profession	*Nursing profession's status*	Lack of clear objectives and strategy for the development of nursing education and consequently the profession. Nursing education and profession reflect characteristics of the hospital-focused Soviet Semashko model developed in the post-communist conservative regime. Secondary-level nursing education provides title of medical assistant. 2001: First Nursing Act, approved by national parliament in 2004. 2003: Nurse/doctor ratio – 86 802:42 538.	Lack of clear objectives and strategy for development of the nursing education and consequently the profession. Nursing education and profession reflects characteristics of the hospital-focused Soviet Semashko model although nursing leaders grew up under a more "liberal" communism. Willing to give up title of medical assistant but not secondary-level education. 2000: First Nursing Act, approved by national parliament in 2005. 2003: Nurse/doctor ratio – 22 372:10 820.

Table 2: Characteristics of selected cases (Source: CIA, 2006)

Case characteristic	Romania	Croatia
Geographical	237 500 km² Neighbours: Ukraine, Moldavia, Hungary, Bulgaria, Serbia	56 594 km² Neighbours: Slovenia, Hungary, Serbia, Bosnia-Herzegovina, Montenegro
Population profile	22.4 million – 5.8% of EU Ethnic composition: 89.5% Romanian, 6.6% Hungarian, 2.5% Roma, 1.4% other	4.5 million – 1.2% of EU Ethic composition: 89.6% Croat, 0.37% Hungarian, 0.21% Roma, 6.22% other (Serb, Bosnian, Italian, Albanian, Slovene)
Languages	Romanian (official), minorities entitled to use own native languages	Croatian (official), Serbian and other minority languages
Life expectancy	Male: 68 yrs; female: 76 yrs	Male: 72 yrs; female: 79 yrs
Unemployment rate and income	2004: 6.3%; 2008: 3.9% 25% of Romania's population, especially nurses, live below poverty level. When compared to the rest of Europe, nurses' salaries are extremely low: €250 per month	2004: 18%; 2006: 11.2% Salaries are low but not below poverty level. At €500 euro per month, official salary of Croatian nurses is double that in Romania
Religion	86.7% Orthodox, 4.7% Roman Catholic, 3.7% Protestant, 1% Greek Catholic and 3.6% others	87.8% Roman Catholic, 4.4% Orthodox, 1.3% Muslim, 0.3% Protestant , 6.2% others & unknown

5.4 Methods and processes of data collection and analysis

In order to deliver the ethnographic approach of the study, a mixed-methods approach to the collection of qualitative data was adopted to ensure accurate capture of meanings, beliefs and values (Arouzi, 2007; Bennett & Colin, 2006; Sprinz & Wolinsky-Nahmias, 2004). This also stimulated a better understanding of rival explanations to claim in a more rigorous way new knowledge on nurses' impact on policy-making (Patton, 2001:553). Establishing the credibility of the findings implied not only the collection of sufficient data from a diverse range of interviewees and settings, using three different data collection methods (interviewing, privileged observing and documentary review), but also adoption of a transparent data analysis process.

5.4.1 Interviewing

Harding (2006) asserts that "interviews are occasions for producing subjectivity through personal narratives in the present that work on and interpret the past with an eye on the future". Interviews can collect personal accounts of the past as part of a process of "giving voice" to the participants (Kvale, 2007; Chamberlayne et al., 2004). Consequently, in the context of the research enquiry, interviewing was the most appropriate method for exploring the diverse qualities, meanings and social worlds of interviewees' experiences (Gubrium & Holstein, 2001). As Arksey and Knight (1999:456) state, interviews are well-suited to provide data "on understandings, opinions, what people remember doing, attitudes, feelings and the like, that people have in common".

Denzin (1994) listed three types of interviews – structured, semi-structured and unstructured. The structured approach felt too confined as the literature review on the policy-making process of former Communist-regime countries during EU accession did not facilitate a theoretical understanding of the topic under investigation. Consequently, at the start of the research study it was not possible to develop a pre-planned script with standardised questions for all participants. Unstructured and semi-structured interviews served different purposes at different stages of the research process. The lack of prior research on nurses' impact on the EU accession process and, equally importantly, the professional and political sensitivity of the study inquiry, dictated that the first set of interviews in Romania (2005–2006) followed an unstructured approach. This option provided the opportunity for each interviewee to raise and identify issues that s/he felt were pertinent to the research enquiry (Harrell & Bradley, 2009).

The open-ended, unstructured interviews were highly individualised and produced insights that could not have been anticipated. Nevertheless, there was a central dilemma that unstructured interviews increased the likelihood of a qualitatively rich array of unique experiences and vantage points allowing complex and sophisticated insights at the expense of achieving greater rigour and case comparability (Patton, 2007; Lacey & Luff, 2001).

The themes and concepts emerging from the unstructured Romanian interviews drove the evolution of a semi-structured approach for the Croatian interviews in 2007. In addition, the first set of unstructured interviews in Romania was followed up by means of a second sequence of semi-structured interviews in April 2010, three years after Romania joined the EU. The outlined topics for discussion guided the semi-structured interviews with the possibility of varying the wording and order of questions for each interview. This allowed for greater flexibility and consideration of each interviewee's level of expertise concerning the different themes explored. This ensured that the most could be learned from the participants and their respective expertise in the field of EU accession. In addition, the guided, semi-structured interview worked well when controlling theme coverage, probing for more in-depth answers and understanding thoroughly the answers provided. The interview guide was a positive support for my own interviewing capabilities and skills, especially when political elites tried to avoid some questions, especially those referring to the Communist regime, political leadership and political party capacity (Werning et al., 2002; Ward & Jones, 1999).

The process of selecting the participants employed a purposive sampling strategy (Patton, 1990) in which individual interviewees in leadership positions in both Romania and Croatia were selected on the basis of their knowledge and involvement in the development of national nursing legislation as part of the EU accession negotiations leading to the implementation of the *Acquis*. The characteristics of the population under investigation (e.g. size, diversity and representation) determined interviewee selection. It was anticipated that the adoption of a non-probability sampling approach would facilitate the capturing of diverse, and perhaps conflicting, perceptions and views leading to the identification of key central themes and concepts which cut across interviewees. The sampling framework (Table 3) consisted of nursing leaders, governmental policy-makers, politicians and journalists engaged in the enlargement process and specifically those negotiating Chapter 3 of the *Acquis*. Anonymity of the participants was guaranteed and

maintained throughout the data collection process and reporting as discussed in the ethics section. A total of 11 interviewees were initially recruited for the study.

Two further sampling strategies were used – personal networking and snowballing. These approaches were adopted to identify and recruit other key participants from the nursing leadership and political elites, as well as policy-makers, in order to ensure inclusion of a broad and diverse range of perspectives (Christopoulos, 2008; Mehra, 2002). My positionality provided the opportunity to develop a network of contacts within Romania and Croatia. Ethnographically oriented research discusses the researcher's position and its implications such as accessibility to participants and data collection bias (Hammersley & Atkinson, 2007; Marshall & Rossman, 1999; Rainbird, 1990). Undheim (2003) indicates that "famous researchers", having a privileged and known position in society, risk never gaining access to interviewees.

Nevertheless, my appointment as the European Commission's TAIEX mission expert for Romania in 2003 provided me with an extensive list of high-level civil servants and politicians involved in EU accession negotiations. Spending some weeks with those negotiating EU accession increased my accessibility to candidate interviewees when sampling started. Furthermore, as President of the Health Grouping of the Council of Europe I had the opportunity to lead a capacity-building seminar in 2006. This provided access to Romanian civil-society stakeholders, high-level policy-makers and politicians. Similarly, sampling for Croatian participants through professional lobby networking was possible due to the EFN's position as observer in WHO Regional Committee meetings. As Secretary General, I therefore came into contact with policy-makers, civil servants, scientists and politicians from Romania and Croatia. These contacts subsequently facilitated access to dissidents, parliamentarians and political leaders who were contacted when sampling started. In networking, social events played an essential role in implementing the strategy for access to participants – gala dinners, social tours in art galleries or just walks between hotel and conference venue provided valuable opportunities to talk to and recruit interview participants. The literature on accessing elites is scarce and even neglected (Coleman, 1996; Hertz & Imber, 1995) but gaining trust relied on establishing a rapport. My position as Secretary General of the European Federation of Nurses Associations (EFN) played a key role in gaining and maintaining access to a diverse group of people in different positions who played central political roles during the regime change in both cases.

Prolonged engagement with a diversity of interviewees, using different sampling approaches aimed to increase the credibility of the research study (Seale, 2002; Merriam, 2002a; Hull, 1997; Maxwell, 1996), resulted in interviews with 11 participants through purposive sampling and 19 interviews with participants recruited through networking and snowballing until theoretical saturation was achieved (Table 3).

Table 3: Selection framework and use of interpreters

Sampling Strategy	**Cases**
Purposive Sampling	Nursing Community Representatives = 5 (3EN, 1FR, 1RO) National negotiators of the *Acquis* = 6 (EN) Total Recruited Participants from Romania and Croatia = 11 Revisited Participants after EU accession Romania = 3 (EN)
Personal Networking / Snowball Sampling	Nursing Community Representatives = 7 (4EN, 1RO/FR, 1CR, 1RO) Political Elites = 3 (2CR) Scientists = 2 (EN) Religious recruited through nursing community = 2 (EN) Global Institution = 1 (EN) Media = 2 (EN) Total Recruited Participants from Romania and Croatia = 19 Revisited Participants after EU accession Romania = 8 (EN)

Data review and analysis were performed in conjunction with data collection so the point at which new data brought no additional insights determined the completion of sample recruitment (Hammersley & Atkinson, 2007; Strauss & Corbin, 1990). As the research objectives reflect the interest of interviewees' contrasting ideas, opinions and views it was more important to achieve a maximum-diversity sample than to represent different views proportionately (Berg, 2004; Skinner et al., 2000).

Data saturation (i.e. when no new concepts and themes emerge from the data) (Strauss & Corbin, 1998) was achieved after conducting 30 interviews, 15 for Croatia and 15 for Romania. A new series of interviews took place in Romania to address research objective 4 – evaluation of the professional and legislative outcomes after Romania's accession to the EU in 2007. No new interviewees were added to the interview group so the sample size stayed at 30 (15 in each case), providing 38 interviews and transcripts for qualitative analysis.

Of the 30 participants, 2 Romanian interviewees requested a Romanian-English interpreter and, in the case of Croatia, 3 interviewees requested a Croatian-English interpreter. Four participants spoke their native language during the interview as they believed that detail and emotions would be lost if they spoke English. Finally, 2 Romanian interviewees spoke French but did not request an interpreter as I am fluent in the language.

Although language was a methodological challenge when sampling Romanian and Croatian interviewees, it did not become an exclusion criterion for being selected for an interview. My first contact with potential interviewees took place in English as all individuals contacted in the recruitment process spoke and wrote Basic English. Nevertheless, the interviews concern emotions, feelings and personal views. In order that the detail of participants' experiences and views was not lost because they were unable to express these emotions in English or French, there was an option for each interviewee to request an independent and professional interpreter. The interpreters (one Romanian, one Croatian) were recruited from my network of European policy advisors. Squires' (2009) methodological guidance on how best to manage interpreters and minimise methodological risks helped in rendering the interpreter visible in the research study as part of the process of knowledge production (Duranti, 2003; Bradby, 2002; Jentsch, 1998; Young, 1997; Simon, 1996; Hammersley, 1995; Stanley & Wise, 1993). Consequently, participants did not perceive the presence of the interpreter as a barrier to openness and honesty. Instead, the interpreter created an immediate 'language brotherhood' which helped to build rapport with the interviewee from the start of the interview (Doerr, 2005).

The benefits of using a Romanian and a Croatian interpreter outweighed the key disadvantage – the degree of bias that an interpreter brings into the data and findings (Hole, 2007; Irvine et al., 2007; Larkin et al., 2007; Wallin & Ahlström, 2006; Esposito, 2005; Temple & Young, 2004; Temple, 2002). Each interpreter paraphrased what was said in either or both directions during the

interview. Therefore, the two competent and independent interpreters gradually identified with their role in the interviews, and then as transcribers of the interpreted interviews (Edwards, 2005; Pan, 2005; Wallin & Ahlström, 2005; Phelan & Parkman, 1995). Interpreting performed in two language directions by the same person is known as liaison interpreting (Gentile et al., 1996) and both interpreters were given the literature on this genre as part of their orientation. This led to the decision that the interpretation should get the message across rather than provide a word-for-word translation of each sentence (Robinson, 2002). Nevertheless, as both interpreters also transcribed the recorded interviews and translated transcripts into English, the risk of bias due to the interpreters'/translators' own cultural experiences, ideas and views is acknowledged (Temple, 2006; Hung, 2002; Thomson et al., 1999; Venuti, 1998, 1995; Gile, 1995; Bowen & Bowen, 1990; Seleskovitch & Lederer, 1989).

5.4.2 Privileged observation

Moug (2007:27) argues that "watching and listening to what people do and how they behave in particular settings and situations is the foundation of all observational methods". Gold (1958) described the potential roles the researcher can adopt in terms of how much he/she participates in the field being observed. One end of Gold's scale is complete participation – the researcher is a 'native' in the field they are observing, including reflexive 'insider accounts', drawing on his/her own experiences as data for understanding the phenomena under investigation. As such, experiences become data only in retrospect as at the time of the situation there was no intention to use them analytically. Instead, when entering the field explicitly to research it, Gold identified the 'participant as observer' and the 'observer as participant' roles in which the researcher participates to a greater or lesser extent in the field studied. Ethnographic account data supplemented with observational data can contribute to a more detailed understanding of the EU accession policy process, thereby allowing crosschecking of the completeness of the interview findings (Fox, 2006; Becker & Geer, 1957). In this study, the observations were used to provide in-depth contextual information to facilitate data analysis, attribute meaning and interpret data from interviews.

In particular, the non-participant observation data collection method is relevant to the research enquiry as it is a method that relies upon a prior relationship while maintaining a degree of detachment from the group under study (Frankfort-Nachmias & Nachmias, 1999). Therefore, my positionality – as both the researcher and the EU lobbyist focusing on the implementation of the

EU Directive on MRPQ – led to the adoption of non-participant observer status within the process of data collection. In fact, this position relates to what Labaree (2002) calls insiderness, the benefits of which include – exposing hidden truths; accessing privileged information that otherwise would be unobtainable; breaking down self-protective behaviours of the target population; enhancing access to political elites and critical information; and being able to interpret the culture of the population under investigation. Furthermore, this observation method provides the opportunity to check for nonverbal expression of feelings; determining who interacted with whom; grasping how participants communicated with each other; and checking for their real intentions and motives when negotiating EU accession (Savage, 2000b; Schmuck, 1997; Jorgensen, 1989).

However, this positioning as a privileged observer brings with it a host of dilemmas relating to what Labaree (2002) calls the insider-outsider debate, and what Moss (1995) interestingly calls the gap of the politics of research. In anticipating a more detailed ethics discussion due to the challenges arising from the privileged observations, the literature discussing public-private accounts of researchers in privileged, elite positions is scarce (Hammersley & Atkinson, 2007; Marshall & Rossman, 1995; Rainbird, 1990). The work of authors such as Shaffir and Stebbins (1991), Shakespare et al. (1993), Chiseri-Strater & Sunstein (1997), Klein & Myers (1999) and, particularly, Smith (1992) and Savage (2000), provides useful generic guidelines on using privileged observation to conduct the fieldwork. The literature on reflexivity offers an additional methodological tool through combining the observations made in my position as Secretary General without having to let go of the observational role of the academic. As reflexivity implies the use of multiple identities, privileged observing increases the likelihood of representing the multiple realities adequately and thus enhances the credibility of the data collected (Francis, 2000). Nevertheless, adoption of different identities has consequences for the type of data collected – participants may behave differently during observation and it is impossible to identify whether participants would do the same things if they were not being observed (Hamberg & Johansson, 1999). Furthermore, reflexivity requires a disciplined approach to note-taking and review of notes made during privileged observations as unbridled use of reflexivity can result in the observer losing sight of what is being studied, resulting in academic vanity (Pels, 2000).

Finally, by adopting a privileged observer status, the reconstruction of the data collection process for future EU accession cases was limited by the contextual boundaries of the events in which these observations took place (Seale, 2002). As a research tool, therefore, techniques of observation are not simple and uncontested (Reger, 2001). However, Tjora's guidelines were helpful in that data were collected to describe participants, interactions, routines, rituals, interpretations and social networks (Tjora, 2006).

Nevertheless, an insider position brings a far greater challenge in gaining analytical distance from the qualitative data, and treating the data theoretically. Therefore, observational data were recorded by adopting Tjora's (2006) suggestions to capture anecdotal records with contextual descriptions in a systematic way. As set out in Table 4, the field notes provided public and private accounts of political and professional events and face-to-face dialogues with nursing leaders, policy-makers and politicians concerning EU accession negotiations, specifically those related to compliance with the European Nursing Directive (2005/36/EC).

Furthermore, at different stages of Romania's and Croatia's accession to the EU, my selection as TAIEX capacity-building mission expert provided the opportunity to observe within the context of the research inquiry what was going on in high-level policy contexts which would have been inaccessible to me in a researcher capacity. Furthermore, at the start of the study, I acted as privileged observer in my role as President of the Council of Europe Health Grouping, leading a capacity-building seminar for nongovernmental health and gender organisations in Romania. All these privileged observations were recorded as written text and converted to research field notes following *The Art of Note-taking* (Webb, 1991) as set out in Burgess's sourcebook and field manual (Burgess, 1991).

Table 4: Privileged observing in both case studies

Cases	Privileged observations
Romania	**Objectives:** Understanding policy context and identifying the key players to develop an open-ended interview guide. **Settings: 2003–2005:** National Nurses Association conferences; **2003**: TAIEX mission; **2004**: Council of Europe Summit on Stakeholder Approach; **2005**: Romanian NGOs' capacity-building meetings. **Outcomes:** Increased reflexivity, development of interview guide for first interviews in Romania (2005–2006).
Croatia	**Objectives:** Understanding policy context, identifying key players and exploring specific concepts which emerged from analysis of the Romanian data. **Settings: 2006–2009:** NNA conferences; **2007-2008**: Informal TAIEX mission events and leadership capacity-building seminars. **Outcomes:** Increased reflexivity; development of a semi-structured interview guide (2007–2008).

5.4.3 Documentary sources

Like observation data, documentary data are restricted to use as aids in gaining meaning from interview data and allowing the writing up of findings to concentrate on emerging themes and concepts.

In addition to interviewing and observing, mining data from documents was the third data collection method designed to gather qualitative data to uncover meaning, develop understanding and discover insights relevant to the research question (Prior, 2004; Yin, 2003a; Hodder, 1994). As suggested by Green and Thorogood (2004), four broad headings of documentary sources were used: (i) public records (e.g. Commission documents, Council of Europe reports, European Parliament plenary and committee reports); (ii) minutes and reports (specifically from TAIEX missions); (iii) e-mail correspondence (with nursing leaders, policy-makers and politicians); and (iv) mass media outputs on EU enlargement with eastern European countries. In contrast to the privileged observer data, one of the greatest advantages of using documentary material is the replicability of the study analysis. This is due to the stability of the data, the broad coverage over

time that forms the context within which the current study operated. Furthermore, these documentary sources were crucial in relation to the research enquiry, mainly the objective related to the professional and legislative outcomes. Further, the documentary sources provided a yardstick against which to measure the completeness of meaning given to the data gathered from the interviews. Hence, the ethnographic data are supplemented with documentary sources that contribute to a richer understanding of the contexts in which the interview data were collected. This facilitates data analysis, attribution of meaning and interpretation of the findings to generate meaningful insights on the EU accession policy process (Becker & Geer, 1957).

My positionality and role as EFN Secretary General enabled me to use my own lobby diary entries, personal notes and experiences as sources of anecdotal information to flesh out the contextual environment and publicly available information. Although researchers are dismissive of anecdotes, while politicians often seems driven by anecdotes, they are like other types of information, including statistics, to which they serve as a useful complement (Rochefort, 1998:146). Researchers often find anecdotes inherently specious, not easily verifiable and misleading, attracting excessive attention among the public and policy-makers to issues that are not widespread. Researchers stay dismissive of anecdotes due to the difficulty in re-presenting the meanings that individuals ascribe to their lived experience and opposing collective understanding derived from individual stories.

However, Rochefort and Aldrich argue that personal anecdotes (e.g. of a particular episode of care) can bear on issues of systemic significance (Rochefort, 1998:143; Aldrich & Leaverton, 1993: 210). Deborah Stone even argues that aggregate facts and figures are just alternative elements of plot and not necessarily more reliable than anecdotes (Stone, 1997). Interestingly, Rochefort argues that a cumulating mass of negative anecdotes may catalyse the regulatory process, but as a single event it provides little guarantee of the design and implementation of effective regulatory solutions (Rochefort, 1998:147).

Weick's (1995) theory of sense-making argues that the construction of identity can be based on retrospective interpretations of past events (Communism, Balkan War,…) which may be elicited through narratives in the form of stories/anecdotes based on past lived experience (Callahan, 2005; Czarniawska, 1998; Gabriel, 1998). According to Snowden (2001), narratives are not just about telling, constructing or even eliciting stories, it is about allowing the patterns of culture

(regime), behaviour and understanding that are revealed by anecdotes to emerge'. As such, capturing the contradictory attitudes, beliefs, behaviours and responses allows gaining a deeper insight or understanding of the impact of nursing leadership on policy design within the context of EU accession of Romania and Croatia.

In this study, anecdotes are used to complete the picture presented by other data and the wider literature. Therefore, when judging the value of the data sources and the information contained in the documents, it was important to ask whether these documents contained information or insights relevant to the research question and whether the data were acquired in a reasonably systematic manner. Furthermore, the quality of the evidence captured from these sources was evaluated by considering the authenticity and accuracy of the documents, their representativeness and their contribution to meaning (McCulloch, 2004; Scott, 1990). As an example, the TAIEX Peer Review reports – reflecting progress made during the accession negotiations and future challenges to be addressed by the Romanian and Croatian governments prior to an accession agreement – were key information sources to facilitate data analysis and make sense of the data collected through the interviews.

Nevertheless, unpublished reports from governmental and nongovernmental organizations were important sources of information on the political processes that produced them. These documents were read with prior knowledge of the topic and with sensitivity to what has been omitted; what solutions are framed as possible; whose voices are present and absent; and the power relationships that exist between the subjects of the reports, the writers and the commissioners. These documents were an essential clue in explorations of the EU accession policy window opportunity.

5.4.4 Data analysis

From a methodological standpoint, the study adopted an iterative-inductive-reflexive approach (Maxwell, 2005). Although no single standard qualitative data analysis approach is widely accepted for analysis of comparative case study data (Maclaran & Catterall, 2002; Neuman, 1997; Coffey & Atkinson, 1996), the main objective of the analysis was to find constructs, themes and patterns to better understand and explain the nursing leadership's engagement in the EU accession policy-making process affecting the development of the nursing profession in both cases. It may be that no theory of the policy process is rich or basic enough to capture the dynamic

policy process involved in EU accession but the adopted inductive analysis approach incorporating a crosschecking and challenging conceptual element can only lead to new knowledge (Sistrom, 2010).

The inductive analysis approach was therefore best suited to reach the study objectives: (i) to map out the policy agenda-setting of the nursing profession in both case-study countries; (ii) to identify the mechanisms by which nursing leaders engage and influence the EU accession policy-making process; and (iii) to examine nursing leaders' views and experiences of the EU accession process and the related outcomes achieved from a legislative and professional perspective at national level.

The analysis was inductive as the themes, concepts and patterns emerged out of the interviews rather than being imposed on the data prior to data collection and analysis (Patton, 1980). Engaging with the data collection and analysis process allowed "diving into the data" to be more holistic than a fragmented and independent analysis of the qualitative data (Hammersley & Atkinson, 2007; Merriam, 2002; Maxwell, 1996; Yin, 1994). Denzin (1994) argues that this art of qualitative analysis can be learned only by doing, and by thinking about interpretation as a kind of storytelling, in which an imaginative and theoretical approach develops by practicing the various conventions.

Nevertheless, consistent with the adoption of a comparative case-study method, each case was first regarded individually. At a later stage, themes and concepts were considered across both cases to achieve the comparative nature of the research objectives. This led to recognition of the need to ensure that distinctive features were captured across both cases, and by time. These three components to analysis are reflected in the writing up of the findings.

The starting-point of the inductive analysis process was coding the interview transcripts by attributing a label to sections of raw data having a connection with the identified concept; assigning a meaning to the label as echoed by the interviewee; and searching for enlarging and refining understanding of existing and emerging concepts and themes as more transcripts were added to the analysis (Coffey & Atkinson, 1996; Strauss & Corbin, 1990; Taylor & Bogdan, 1984).

This coding process to identify structure in the raw data was facilitated by the NVivo software package (Bazeley, 2002). Although the literature shows no consensus on the use of software packages, more than a few noted qualitative theorists encourage the use of qualitative data analysis software tools to assist the analysis process (Lewins & Silver, 2007; Bringer et al, 2006; Berg, 2004; Merriam, 2001; Silverman, 2001). NVivo was used for manual coding of all transcripts and attributing text references to emerging concepts. Although the starting list of concepts could be extracted from the research objectives or existing policy literature, preference was given to concepts named by the participants. For instance, many interviewees talked about how the Communist regime was experienced and how this impacted on their daily life. Participants used the concept of living a double life – which individuals described as wearing "two coats" – in order to survive the Communist regime. Due to its prominence throughout the interviews, double-life identity was identified as an overarching theme.

As the analysis progressed, participants expressed different views related to this double-life identity, using terms such as their professional identity and their political identity. The literature describes the main use of transcript coding to be for reduction and management of data but in this study it was equally used to identify a structure in the interview data without reducing the evidence of the story. Thus, NVivo facilitated the inductive-iterative coding process by making coding highly reflexive and ensuring that the themes and concepts identified stayed consistent with the participants' views and meanings throughout the analysis. It was important that interviewees' opinions were not diluted by the analysis process and so iteration, induction and reflection were used to empower the voices of participants.

Nevertheless, concepts and themes (and their labels) did not emerge in isolation. They were also driven by what I wanted to know and how I interpreted the data. Kirk and Miller (1986:21) suggest that validity in qualitative research is: "… a question of whether the researcher sees what he or she thinks he or she sees" so that there is evidence in the data for the way in which they were interpreted. Therefore, the reflexive-inductive analysis of the privileged observation and documentary data functioned mainly for supplementing, crosschecking and even challenging the identified themes and concepts derived from the primary sources – the ethnographic accounts obtained via interviewing. Thus, the content analysis of the field notes and documents led to a more comprehensive understanding of the complexity of the accession policy process within an enlarging EU.

5.5 Ethical considerations

Ethical and research governance approval were obtained from the King's College Research Ethics Committee on 20 February 2006, with reference 05/06-61.

The ethical considerations acknowledge first the necessary protections needed for participants engaging in the interview (Hammersley & Atkinson, 2007; Murphy & Dingwall, 2001; Fine et al., 2000; Denzin & Lincoln, 2000; Merriam, 1998; Tourangeau & Smith, 1996; Stake, 1995) with specific attention to the use of an interpreter during some interviews. Incorporating confidentiality to protect participants from potential harm, the informed consent played a significant role in the research process, signed off by the concerned parties, the interviewee, the researcher and (where used) the interpreter (Freed, 1988).

Murphy and Dingwall (2001) highlight how interviewees may experience anxiety, stress, guilt and damage to their self-esteem during interviewing but study participants did not show any visible signs of embarrassment concerning their views and opinions. Instead, most participants saw the interview as an opportunity to express their views and ideas to the researcher and EU lobbyist. Nevertheless, the need to ensure interviewees' anonymity, and to be thoughtful when handling sensitive data (Fine, 2001), stayed central throughout the entire research process as the risks associated with participation in the study relate to the disclosure of politically and professionally sensitive data. In building the sample, the reliance on relationships to expand the participants' network implied that the anonymity of each individual taking part could be compromised by the fact that participants either know or can trace each other. Given the political and professional sensitivity of the research inquiry, there was a possibility that some participants might come under the surveillance of their peers, knowing the secret police anecdotes are still fresh in the mind of all interviewees.

Taking the topic of confidentiality further, it is important to acknowledge that participants involved in a research study could perceive the study as a potential threat to their public 'brand' (Aaker, 1996) and their position can be at stake when their privacy is not adequately guaranteed. Adherence to dignity and respect for participants confers an obligation to respect their values and interests wherever possible in order to protect interviewees from potential harm (Thomas, 1996a). Therefore adoption of an ethnographic approach was central to create a more intimate space

(Stacey, 1988) in which the participant shared personal stories that would not have been disclosed.

Equally important are the ethical considerations arising from observations and the use of personal notes. Although the research ethics literature provides guidance on protecting interviewees, there is less guidance concerning research question and objectives embedded in the dichotomy of *modus operandi – the insider-outsider position* – making reference to the elite position of the researcher (Hammersley & Atkinson, 2007; Marshall & Rossman, 1999; Rainbird, 1990). As set out in the description of my positionality throughout Chapter 1 and 2, the duality of being both researcher and EFN Secretary General guided the formulation of the research objectives and drafting of the interview guide while providing easier access to interviewees and EU accession documentation. Therefore, being ethically transparent throughout all phases of the research process implied being explicit about my role in the EU policy process.

It is important to acknowledge how my positions – EFN Secretary General; expert in the TAIEX capacity-building mission for new applicants to the EU; and President of the Health Grouping of the Conference of International Non-Governmental Organisations of the Council of Europe from 2003 to 2007 – not only influenced the design of the research study but also facilitated better access to political elites (Lilleker, 2003). Hence, within the context of the research inquiry, I was able to make observations within these high-level policy contexts which would have been inaccessible to me in a purely researcher capacity. However, as a PhD student, my affiliations with European and international institutions could put me in a more powerful or even a more vulnerable position with interviewees, depending on the duality of the 'insider' or 'outsider' position within the EU policy process (Chamberlayne & King, 1996; Soydan, 1996). Congress participants generally perceived me as the EU lobbyist – hanging around, observing, asking questions, taking discreet notes and spending time talking one-on-one with nurses and policy-makers.

Therefore, it was critical to use a multi-step process to achieve transparency by using forums to receive methodological questions and gather nurse leaders and policy-makers perceptions of their country's accession to the EU (Kaufmann et al., 2005).

Notwithstanding all these efforts, most participants perceived my position as EFN Secretary General to be more relevant to their personal and professional agenda, although some interviewees used the research student modus to articulate their views and experiences. The

political and professional elites understand the influence that the EFN Secretary General can exert over their country's government policy development, so they used the interviews as opportunities to vent their concerns and views. Therefore, it was important to develop a trusting researcher-interviewee relationship to correct for the asymmetry of information.

The asymmetry of information was corrected by providing political and professional information on the EU enlargement process and the methodological experiences of developing diagnosis related groups with the Nursing Minimum Dataset and its implementation into the financing of the health system in Belgium. My background and expertise in a previous role gave the professional and political elites valuable information to develop their national strategies, policies and even their careers. Some participants, mostly scientists, took the opportunity to explore the dilemmas of the implementation of the Bologna process in their country and used EFN policy statements to articulate and strategise their own arguments to advance their professional and political agendas (De Laine, 2000; Seldon, 1990). Most political leaders used their interviews to present their views on the Communist regime and provide clear views on their personal version of the Balkan War. Their stories can live on through the research study, although anonymity puts these in a more protected sphere.

Finally, it is important to acknowledge the dilemmas concerning how to publish and, most importantly, the likely readers and the possible uses of the data. Despite the stories uncovered, the evidence to develop new knowledge, it is important to consider the impact of the research findings on future relationship between the EFN Secretary General and the political elites in both cases. The challenges cannot be addressed without acknowledging the study findings' impact on the development of the nursing profession and the consequences for nursing leaders and policy-makers. Unflattering publishing conclusions cannot be censored but it is important to be aware that study findings can be appropriated and used in a harmful way that distorts the context in which the information was shared (De Laine, 2000). This requires consideration of what potential audiences may be and how they may use the findings to support their own cause. This includes thinking about the political dimensions surrounding the research project. Although the ethical considerations focused mainly on the duality of my role, positionality was an essential issue throughout the whole research process. Reflexivity became a reality due the acknowledgment of these different identities. Therefore, these ethical considerations should lead not only to a more

transparent research process, but also to new scientific knowledge in developing practical guidelines for researchers.

Table 5: Identity transparency and ethical challenges

	Participant	**Political leader**
Researcher	Paradox – mutual control – information asymmetry – interviewee's vulnerable position – sensitive information increases vulnerability – privileged observer creates unwarranted suspicion. Interview intrusive experience if information "fell into the wrong hands" – getting the "story" published. Translator and confidentiality.	Disclosure of political and professional sensitive data – confidentiality and anonymity – informed consent process not just one-off bureaucratic act. Correction for information asymmetry – vehicle to articulate and strategise ideas and develop professional and political career. Losing/increasing public/scientific 'brand'.
EFN Secretary General	Reflexivity and positionality. Balance between insider and outsider. Privileged observer. Position influenced what and how interviewees provided specific knowledge.	Direct accessibility to political and professional elites. Common intimate story and better understanding of context – strengthening political/lobby relationship. Textual product is an authoritative document impacting on future relationships and policy developments.

5.6 Trustworthiness of the study

The usefulness of the concepts of validity and reliability in qualitative research has been debated for many years (Kelle & Laurie, 1995). Some researchers suggest that these terms are inappropriate for qualitative research, preferring to use terms such as "trustworthiness", "rigorousness" and even "quality" of the research study (Welsh, 2002; Del Siegle, 2002; Guba, 1981). Four key principles were used to assess the quality of the research study: that the research should be contributory, defensible in design, rigorous in conduct and credible in claim (Rolfe,

2006; Spencer et al., 2003). Consequently, the trustworthiness of the research study was evaluated by asking four basic questions (Marshall & Rossman, 1999; Robson, 1993).

1. How can one establish confidence in the 'truth' of the findings for the context in which the enquiry was carried out?

   Credibility, referring to the internal validity (truth value as construct), examined the congruence between the findings and what was observed and referred to the appropriateness and accuracy of the data sources and interpretations. Transparency was the crucial driver for obtaining and demonstrating truth value in the research process and outcomes by showing that the inquiry was carried out in a way that ensured that the subject of the inquiry was accurately identified and described throughout (Robson, 1993). The reader needs to be convinced of the credibility of the research process and findings given the existing knowledge, nature of the phenomena and circumstances of the research (Marshall & Rossman, 1999; Silverman, 1993). Capturing in a reasonably systematic manner the contradictory attitudes, beliefs, behaviours and responses based on anecdotes allowed gaining a deeper insight and understanding of the impact of nursing leadership on policy design within the context of EU accession of Romania and Croatia. The quality of the evidence captured from these sources was evaluated by considering their authenticity and accuracy, their representativeness and their contribution to meaning (McCulloch, 2004; Scott, 1990).

2. How applicable are the findings to another setting (e.g. future EU accession countries)?

   Transferability, referring to external validity (applicability as construct), relates to the idea that the research design and findings will be useful to others in similar situations, with similar research questions (Polit & Hungler, 1999; Robson, 1993; Rose, 1992). To facilitate transferability, it is valuable to give a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analysis. A rich and vigorous presentation of the findings together with appropriate quotations will enhance transferability. Concerning the applicability of findings for future EU accession countries such as for instance Albania, or Serbia, Turkey and even the Ukraine, the provision of detailed, rich, contextualised descriptions of the policy-making context can give the reader sufficient information to assess the degree to which the comparative case study findings can be transferable to other settings (Seale, 2002; Hirschman, 1986).

3. How can one have confidence that the findings would be replicated if the study were repeated in the same (or similar) setting, in the same (or similar) situation?

   Dependability refers to the reliability (consistency as construct) of the measurement and accuracy of the data collected, methods and procedures used (Verma & Mallick, 1999). Rendering a construction of the EU accession policy process by acknowledging the impact of personality and striving for transparency about potential influences is key to increasing the trustworthiness of the study (Hirschman, 1986).

4. How can one be sure that the findings reflect the participants and their situation and context, and not the biases, motivations, interests or perspectives of the researcher?

   Confirmability refers to objectivity (neutrality as construct), the degree to which the interpretations are demonstrated neutral. The confirmability of findings was therefore based on my reflexivity, world view, biases, theoretical orientation and values (Merriam 2002a). My reflexivity was at the forefront of the thesis and included the acknowledgment of dilemmas encountered in the process, including ethical issues (Hull, 1997). The issue is whether enough has been told about the study for the reader to be able to assess the adequacy of the research process and whether the findings flow from the data (Marshall & Rossman, 1999). Again, transparency is necessary to allow the reader to judge the decisions taken by the researcher.

Table 6: Assessing the trustworthiness of the research study

	Question	Approach
Credibility	Is the study carried out in a way that ensures trustworthiness of the research process and findings? How congruent are the findings with what is being observed? Has a significant amount of material/ data been collected? Are there any "hidden agendas," disagreements or other personal or organisational issues? (Sayer, 1998; Myers & Young, 1997).	Being explicit about the setting, population (sample) and theoretical existing knowledge –delivered by detailed theoretical chapters, in-depth documentation of research approach and design and thorough description of case contexts and analysis approach. Check with interviewees but being careful about potential biases – achieved by repeated interviewing of same respondents within cases. Explore analysis and conclusions on a continuous basis through discussions with supervisors and peers. Achieve prolonged engagement by investing sufficient time to become familiar with the setting. Use triangulation, including several perspectives, to obtain a holistic understanding of policy-making.
Transferability	Does the research study offer rich insights? Are the research findings applicable to other settings? Are the findings useful to others in similar situations with similar questions?	Iteration between literature and study. Select cases in order to obtain a wide variety of data observations and provide thorough descriptions of case contexts. Specify everything that a reader needs in order to understand the findings and how they were reached – providing a rich chain of evidence and explanation. Use triangulation, including several perspectives, to obtain a holistic understanding of policy-making.

Dependability	Are the measurements stable and consistent? Are the research findings consistent with the data collected? Is there sufficient information about the research method?	Ensure validity of the findings – it is important to know what I did and how. Keep extensive and transparent files of research project for potential auditing by other researchers – use of software package NVivo; documentation of methods, procedures and decisions made; sample selection; and explanation of the categories used. Use triangulation – include several perspectives to obtain a holistic understanding of policy-making – be specific about views of different interviewees.
Confirmability	Can the adequacy of the research process and findings be assessed? Were the dilemmas encountered during the research process acknowledged?	Keep extensive and transparent files of research projects for potential auditing by other researchers. Be explicit about my reflexivity, world view, biases, theoretical orientation and values – focus on ethical considerations. Elaborate reporting of research process and drawing of conclusions. Use of software package NVivo.

5.7 Summary

This chapter makes transparent and justifies the methodological and method choices made throughout the research process. The research process was made transparent through detailed discussion of the development of the research design. This led to rigorous research findings. Prior to designing the research study, the literature review and presentation of my positionality formed the basis for formulating the research question and the detailed objectives underlying the study.

A comparative case study using an ethnographic approach was chosen as the research method best suited for exploring the implementation process of the Sectoral Directive on MRPQ (Directive 2005/36/EC), looking specifically at the nursing profession's engagement in the negotiation and

subsequent implementation process surrounding it. The key arguments for this particular choice of methods were the particular nature of the research question and objectives; the type of data needed to answer the research question; the importance of reflexivity; and the capacity for building theory.

Case selection represented an important aspect of building theory and therefore the reasons for selecting Romania and Croatia to explore the research question were described in detail. The criteria for selection related to their different historical and political contexts; different positions within the EU accession process; and different levels of health-policy reform and development and organisation of the nursing profession.

Furthermore, the study adopted a purposive sampling strategy in which interviewees were selected non-randomly from a small, specific, predefined and difficult-to-reach group on the basis of their knowledge and engagement in the development of national nursing legislation as part of the European Commission negotiations leading to the implementation of the *Acquis* in Romania and Croatia. To reduce selection bias, the purposive sampling design was complemented with snowballing. The interview group consisted of thirty participants prior to accession and eight interviewees in Romania after joining the EU. Furthermore, the issue of language was given close consideration during recruiting and in taking forward the interviews by the most ethical and rigorous approach. In addition to the open-ended and semi-structured interviews, two other data collection methods and procedures were chosen – privileged observations and documentary. The comparative case study following an ethnographic approach produced large amounts of qualitative data. NVivo software was used from the start, mainly for coding and identification of categories, themes and patterns emerging from the interview data. Nevertheless, this was only a tool as only humans can perform the coding and ultimately identify emerging themes; the name attached to each theme; and the meanings extracted from patterns and comparison.

Adoption of a qualitative research approach had limitations such as time and resources for collecting and analysing data; the necessity of using academics familiar with qualitative approaches; and the continuous need to think vertically rather than horizontally. Furthermore, as the sampling was dependent upon contacts, there was a risk of selection bias due to my positionality and participants' subjectivity.

It was therefore crucial to ensure ethical transparency throughout all phases of the research process in order to increase the trustworthiness of the study.

Although it was impossible to have certainty about any knowledge claim, the main challenge was to search for new empirical knowledge in policy-making with a reasonable degree of trustworthiness. Therefore, maximum transparency was achieved by assessing the credibility, transferability, dependability and confirmability of the research data and process. It is for the reader to judge whether this has been achieved.

Having described the framework and process of the research, the next chapter presents and discusses the findings.

Chapter 6 The Romanian case study findings

In this chapter the research findings on the process of Romania's accession to the EU are presented and critically evaluated. The findings are based on an analysis of 20 interviews alongside 2 key sources of evidence – the TAIEX peer review reports and the Commission's comprehensive monitoring reports discussed in the European Council and the European Parliament prior to EU accession. These demonstrated that Romania's progress is blocked by a lack of nursing leadership and a lack of unity between stakeholders engaged in the compliance process. The aim of this chapter is presentation of the evidence demonstrating that the EU accession process provided no policy window for the Romanian nursing leadership to advance a professional agenda in Romania.

The case study findings are framed according to the research objectives, starting with analysis of the policy context which helped and hindered the nursing leadership's engagement with the EU accession policy process. The inductive analysis revealed that four regime-specific contextual conditions helped the Romanian nursing leadership entering the EU accession policy process: (i) living through a totalitarian regime; (ii) double identity; (iii) nursing role models, networks and leadership; and (iv) civil society advocacy. Three indicators were identified as the main barriers to the nursing leadership's engagement with the compliance process for Directive 2005/36/EC: (i) Soviet Semashko working ethos; (ii) medical domination; and (iii) political instability.

Furthermore, the critical analysis of the mechanisms that the nursing leadership used to engage in the EU accession process reveals that the Commission’s mechanism to evaluate the design of national legislation in compliance with Chapter 3 of the *Acquis* do not have the strength to provide effective stakeholder engagement. Although the TAIEX peer reviews were an important mechanism to advance the nursing agenda in Romania, their recommendations were not picked up sufficiently by the Commission's comprehensive monitoring reports. As there are no precedent for this kind of policy intervention which could build on established coalitions, it can be argued that the nursing profession's overall capacity to influence the policy process (and thereby the legislative and professional outcomes) was weakened considerably by the nursing leadership's inability to harness a unified and coordinated position in relation to the Acquis. This lack of unity undermined compliance with Directive 2005/36/EC.

Finally, the study objective focusing on the policy agenda of nurse leaders and the extent to which policy goals have been achieved in Romania is critically examined. This is based on the stakeholder mapping of views, interests and influence on the design of the Romanian Nursing Law in compliance with the European Directive on MRPQ (2005/36/EC). Findings reveal that compliance was achieved only for nursing students graduating from four years after the 2007 accession date; the entire Romanian nursing workforce trained prior to EU accession is subject to non-compliance, thus these nurses are in a more vulnerable position when seeking to move to other EU MS. It is therefore argued that the main aim of compliance with the EU Directive on MRPQ – for nurses to move freely for work throughout the European Single Market – has not been achieved. Furthermore, when considering the professional outcomes, the nursing leadership's diverging interests and powers stopped Romanian nursing leaders from seizing EU accession as an opportunity to move nursing away from a sanitary vision and improve working conditions in the Romanian health-care system. Nevertheless, the fact that nursing leaders from the Romanian Nurses Association (RNA) continued to lobby Romanian parliamentarians after the EU accession date indicates that EU accession is not seen as an end in itself.

The chapter concludes by summarising the Romanian case study findings to enable comparison with the Croatian case study findings and to benchmark these findings against the existing policy literature.

6.1 Policy context

Findings indicate that the policy context determined the way that the nursing leadership entered the EU accession process. Analysis of the Romanian accounts identified seven regime-specific contextual factors which impacted on the way the nursing leadership influenced policy-makers to reach compliance with Directive 2005/36/EC.

6.1.1 Living through a totalitarian regime

All participants confirm that Romania presents a unique case study as, from the 1970s until December 1989, the Ceausescu regime pulled an entire society into extreme poverty and forced Romanian citizens into a continuous fight for survival. Some nurse leaders and policy-makers consider the period between 1965 (when Ceausescu came to power) and 1980 to be a period of

cultural development. The construction of the Casa Poporului [House of the People] is one example. (R3 Nurse Leader).

> "The communist period, especially the dictatorial one, meant for everybody a lack of access to information and destroying intellectual capacity with communist activists taking the lead. After 1990, I realized that actually we had all become numb." (R1 Nurse Leader)

All participants indicated that Romanian society started to degrade when Ceausescu started these constructions to host the Communist Party activities. During the regime change, study participants reported that the new leaders of Romania referred to the building as the House of Ceausescu to highlight the excessive luxury in which Ceausescu lived, in stark contrast to the squalor and poverty endured by many people living in Romania.

As indicated by a policy-maker in the Romanian government, Ceausescu's actions led to measures which deprived citizens of essential goods and services by cutting electricity, access to television programmes and access to food. Several interviewees provided their own accounts of food being sold on the basis of ID cards and prices being deliberately kept low enough: "to ensure that there was more money available than there were goods to buy" (R9 Nurse Leader).

> "The access to information was non-existent. Readings consisted of information on the Party, about Ceausescu, about the communist system. Parents used to be very careful that information they had obtained did not reach the children, because children could talk afterwards and spread it." (R2 Nurse Leader)

Another physician/policy-maker interviewed stressed that it was important to have money, but it was even more important to have access to goods and to be allowed to buy them (R4 Politician). He went on to say that "everybody had a very poor life and it became an achievement for each individual to find butter and bread, to stay in a queue for a couple of hours to get something which was available to everybody". He concluded by saying that people said "they do give this in that store" instead of "they sell this" (R4 Politician). Although the Ceausescu regime did not tolerate poverty, several participants regarded it as an instrument "to control society and to keep people down" (R1 Nurse Leader; R4 Politician; R8 Policy-maker; R11 Nurse Leader/Policy-maker). It is within this policy context that nurse leaders grew up and prepared themselves for EU accession.

Participants held a common view of the Ceausescu regime's extreme negative effect on the daily life and work environment of most Romanian citizens. However, the accounts confirm that there were different phases in this regime and highlight Communism's positive impacts on the nursing leadership.

> "The period from '65 – when Ceausescu came to power – to the '80s, was a period of cultural development. Things were well structured, the system was soviet. Because of fear, teachers were doing their job. Fear was one of the things that obliged them to obey and do their job. " (R1 Nurse Leader)

Several participants shared their opinions that, when queuing to buy food, it helped "to have some connections in the political system otherwise you had to queue for a long time". Among all the nurse leaders participating in the study, only two openly confirmed their membership of the Communist Party and explained how this helped to ease their career pathways.

> "I was a leader for the young people's communist organisation. I learnt to be a leader, I learnt to speak in public, I learnt to communicate and work with people. I completed a Communist Party course to organise various meetings with young people." (R6 Nurse Leader)

Several interviewees provided examples of the advantages of being connected to Communist Party members. Students accepted membership of the Communist Party as they then received 20% extra marks for the final graduation grade that helped them to get a better job and a loan for an apartment in Bucharest. Involvement in the socialist youth movement and being nice to the right people at every level of the political party hierarchy also helped to enable survival in daily life. Some nurse leaders and policy-makers indicated that those leaving Romania for an international nursing conference were required to sign documents confirming that they would never share what they saw while they were away in the West. At those times it helped to have connections in the party or to be a party member: "If you wanted to go on holidays, you needed the connections in the Communist Party" (R1 Nurse Leader).

The majority of nursing leaders interviewed refused party patronage after being asked to play a role in the Communist Party hierarchy. Many participants argued that, for the nursing leadership, staying out of the party implied "knowing the system", and/or "operating in the system" in order to get something or change things in nursing.

Participants stressed that “it helps to have some connections in the political institutions, in the Ministry of Health, to push forward your own ideas” (R11 Nurse Leader/Policy-maker; R3 Nurse Leader; R6 Nurse Leader; R1 Nurse Leader). For the nursing leadership, operating in the system implied “knowing who is who”, “never saying no” and “always showing appreciation to the political leaders”. Many interviewees therefore make reference to “developing different individual identities to protect yourself and be successful in the system” (R2 Nurse Leader; R7 Policy-maker; R3 Nurse Leader).

6.1.2 Double identity

During the totalitarian regime Romanian citizens survived by developing a double identity, characterised by a duality in behaviour. As described by a nurse leader:

> “There were two pictures, two coats, two systems: when people went outside of the house in the morning they put on another coat and became another individual at the workplace. Coming back home, that coat was left outside and another was put on.” (R1 Nurse Leader)

Participants added that the double identity needs to be interpreted within the context of the Communist regime in which a small group of party members was at the centre of policy-making. Simultaneously, a narrow segment of dissidents developed their own alliances (even connections within the Secret Police – the Securitate) and the huge silent majority used their ability to wear “two different coats at the right place, at the right time” (R3 Nurse Leader; R9 Nurse Leader). According to most interviewees, surviving the totalitarian regime required the ability to cope with “fear and control” (R5 Nurse Leader) within a system in which you could not trust anybody. The fearfulness during this period is exemplified by the following quote:

> “It is not that kind of fear when you are in front of a lion. Because the lion, you can see it. But this fear, you never knew from where the danger was coming. This was awful.” (R5 Nurse Leader)

This was the direct result of the Ceausescu regime establishing the Securitate, the “internal enemy” (R2 Nurse Leader), consisting of special units encouraging individuals to spy on friends and betray lovers, making sure that neighbours informed on people marrying in church or producing subversive literature (R8 Policy-maker; R12 Physician/Policy-maker): “The secret

police force wormed its way into people's families, homes, workplace and schools, relying on informers as young as 12." (R4 Politician)

Many informants argued that this made the nursing leadership stronger as the Ceausescu regime created a system in which individuals wanted to extend your own limitations and boundaries. This was explained by two nurse leaders:

> "We had to be stronger, to find ways and solutions to live through the regime.'(R1 Nurse Leader)

> "We strengthened ourselves in that regime. We had so many restrictions and, due to them, we had to fight much more." (R3 Nurse Leader)

Participants reported that the nursing leadership had to develop through informal networks to cope with the harshness and duality of a totalitarian regime.

6.1.3 Nursing role models, networks and leadership

Participants indicated that far from creating blind compliance, the Communist regime seemed also to create a society in which people wished to do what was forbidden (R11 Nurse Leader/Policy-maker; R3 Nurse Leader; R6 Nurse Leader; R1 Nurse Leader).

> "Here there were groups of people who wanted to escape from the system in which one wishes to do what is forbidden. You want to do what you are not allowed to do." (R1 Nurse Leader)

To cope with living through the totalitarian regime, nurse leaders belonged to informal networks designed to support mutual aid in which "I help you and you help me" (R2 Nurse Leader). So the more connections established within an individual's personal networks, the easier life became. Most interviewees mentioned the importance of their networks so this theme became identified as an important condition to support and strengthen nursing leaders' impact on policy development prior to EU accession.

According to some participants, the "informal network of trusted friends and role models in nursing" is not only central for security and individual safety (R8 Policy-maker; R10 Nurse Leader) but also is essential to provide "a sense of justice and democracy" which provides the energy and continuous commitment needed in a period of regime transition. Most nurse leaders interviewed

reported that their alliances within the nursing profession at local and national level (and even within government structures) provided security, strength and even courage to continue advocating for the values and holistic approach of the nursing profession. As one nurse leader explained:

> "Your knowledge and your values are most important to develop the nursing profession and nobody can take them away from you. Nobody can break you down. You need to develop the profession in order to serve the people around you."(R5 Nurse Leader)

Data show that networks of friends and role models developed from an altruistic perspective and from a pragmatic need to survive. Interviewees make reference to Lucretia Titirca (author of nursing books, lecturer at the University of Craiova), Teodora Gându, Eugenia Costici and Gabriella Bocec – all nursing leaders advocating the advance of nursing as a profession in Romania.

> "Through Margaret Kruse I met Teodora Gându and Eugenia Costici who were role models for me. We became very close and through them I met other nurses from Cluj and Timişoara. This made me understand better what I needed to do to develop nursing as a profession." (R3 Nurse Leader)

These networks of role models became important 'support networks' for the nursing leaders entering the EU accession policy process. Best practice exchange took place without any formal structure – nurse leaders would meet informally in private homes and share the literature that some had brought from abroad. These informal discussion groups were identified by participants as a key way for nurse leaders in Romania to debate and benchmark their ideas and move their professional agenda onto the political agenda prior to EU accession.

> "I am one of the fortunate persons as my brother had left the country in the '80s, to Sweden, and I had much more information coming from there. Over three months I discussed with my colleagues the EU directives and we explained things to each other, and agreed on the way we needed to position ourselves." (R1 Nurse Leader)

A good example drawn from the interviews concerns the 1990 visit of a WHO rescue team. This travelled to Romania immediately after the fall of the Ceausescu regime in order to establish the

priorities for health and education for inclusion in an agreement between the Romanian government and WHO. The nursing leadership was part of this process and became involved in discussions with the former Minister of Health, Professor Enăchescu, who agreed to put nursing education as the third priority on the national health policy agenda, after maternal and child health.

> "Mary Farrell and Elisabeth Desito were members of this WHO team and supported the Romanian Nursing Association aim to make nurses better informed, better educated, better involved in policy-making." (R3 Nurse Leader)

Thus, most participants perceived that role models offered inspirational support to continue advocating by creating opportunities to meet informally to discuss ideas, frustrations and disappointments. These informal initiatives became part of the nursing leadership culture: "Their attitude attracted me and I followed them." (R1 Nurse Leader, R6 Nurse Leader).

Nevertheless, the nursing leadership went beyond the individual networks within nursing. Interviewees perceive Romanian civil society as a very strong, organised interest group that stayed underground until 1990. Prior to EU accession, non-governmental organisations (NGOs) within civil society came to play an important role in holding politicians and policy-makers accountable for their policy actions.

6.1.4 Civil society advocacy

Most interviewees belonged to discussion networks in which, irrespective of their place or position in society, people came together to exchange views and discuss politics (R8 Policy-maker; R10 Nurse Leader). Participants reported that these informal non-governmental networks were very active underground during the Ceausescu regime and civil society in Romania was more vibrant and more sophisticated than perceived in the West.

The analysis of the Romanian accounts also identified the theme 'civil society advocacy' as one of the indicators facilitating the nursing leadership to have more impact on the EU policy process. Within the transition towards democracy that began in 1990, civil society started to play an essential role in developing health and gender policies at national level.

Some participants described civil society as consisting of a well-organised network operating in the field of market economy and political ideology (R16 Policy-maker). One interviewee describes this: "all the glory needed to go to the Communist Party during the Ceausescu regime and

although the Catholic Church was the main opposition for Communism, this took the focus away from a marginalised civil society being tolerated during this regime period and being able to develop itself" (R3 Nurse Leader). Nevertheless, one participant indicated that, between 1989 and 2000:

> "the word 'democracy' was 'brought' to Romania, but operationalised within the Romanian institutions based on a Romanian mentality with Romanian people, which meant that it was not really a democracy in fact... It was only… you know… that you changed the title of an institution: it was not the socialist Ministry of…, it was called Democratic Ministry of …, but the mentality to make policies was the same." (R16 Policy-maker)

To change this mentality, 60 Romanian health and gender NGOs focused on human rights and democracy organised a capacity-building seminar under the umbrella of the Council of Europe. It was unlikely that the researcher would have been exposed to the findings from the seminar had he not also been working as a lobbyist in his day job and the possibility that my perception was coloured by that role cannot be discounted.

These NGOs, including the Romanian Nursing Association (RNA), pushed for the development of a common policy agenda consisting of a list of human rights topics for which they would advocate with the Romanian government as part of the *Acquis*. Some interviewees suggested a need for civil society advocacy work – focused on respecting international and national human rights legislation in which monitoring of the enforcement of the Romanian law on patient rights (46/2003) and the implementation of a patient-centred approach in the public and private health-care systems need to become central in the policy and political debate (R16 Policy-maker; R8 Policy-maker; R5 Nurse Leader). But, as expressed clearly by one participant: "I know NGOs can be influential when you have the tools and the means to be influential" (R16 Policy-maker).

As the idea was to move away from the Soviet Semashko model in which Romanian nurses had operated, monitoring the enforcement of the ethical code of conduct for health-care providers and ensuring that human rights are respected in service delivery became central to the capacity-building debate between the participating stakeholders. Informants stressed that although "each profession started a process of beginning to be recognised as a profession, the process is difficult in a society which is not transparent" (R16 Policy-maker).

She continued: “although each profession started to develop an ethical code of conduct, there is a continuing perception that health professionals are not acting ethically.”

Furthermore, several participants stressed that, prior to EU entry:

> “Nurses were powerless. They can act, but they are not invited to the table to decide. This is not connected only to nurses; it is connected to everything which is not institutional. And this is connected to the principle of a participative civil society and political dialogue” (R16 Policy-maker).

As a result of the capacity building event, the Ministry of Health representative promised to set up a liaison committee for civil society and provided the stakeholders present with information on the upcoming election for members of the Economic and Social Council. Nevertheless, participants indicated that although cooperation between governmental institutions, ministries and NGOs is written into Romanian law, and a dialogue has started to move the civil society voice into the structures of the policy-making process, participants do not see this functioning effectively.

> “The Ministry sends a law on the market, a draft law, and they start debating its process, or there is a public presentation and discussion with the different stakeholders concerned, but the reflections and input are not taken into account when developing the final legislative proposal.” (R8 Policy-maker)

Nevertheless, some interviewees believe that institutions and NGOs should become more mature in policy-making and more focused on the public interest rather than working for their individual interests. As one policy-maker from the Council of Europe stated:

> “When we debate policies, we debate the public interest. Today, policy-makers, politicians and even NGOs are all running for their own purpose, for their own interests, my interest. And very rarely you have persons fighting for the public interest.” (R16 Policy-maker)

When it comes to self-interest, even corruption, all participants perceive the health-care system in Romania to be corrupt. Consequently, the Soviet Semashko working conditions (mainly the extremely low salaries) were identified as one of the three main barriers for policy engagement. This, and the two other barriers – physicians' dominance within nursing education and the health-care system, and the lack of trust in politicians – are explored further below.

6.1.5 Soviet Semashko working ethos

The Communist regime obliged everybody to do voluntary work and therefore, in reality, the voluntary work became mandatory with informal payments (also termed 'under table payments' or 'envelopes') as a result. Everybody was supposed to work for the benefit of the community but there was no option to work voluntarily for the benefit of the community (R2 Nurse Leader; R7 Policy-maker).

> "In 1987 I started working in a place where we pretended to work, but we had to do extra hours to show that we can work for pleasure for the Communist Party." (R7 Policy-maker)

Consequently, informal payments (tipping) became universal in the Romanian health-care system and society (R8 Policy-maker; R4 Politician; R10 Nurse Leader). Due to the extreme low working conditions in the Soviet Semashko system, tipping became part of the daily working ethos.

> "The big mountain they have is that they are not paid enough. So they have to be ethical in a system which is not rewarding them for the work they do. And because of that there are a lot of nurses who are not doing anything without being paid cash by the patient. So this is the problem. Here it is the big, very big problem." (R16 Policy-maker)

Under the Communist regime there was no differentiation between a worker, a lawyer or a doctor, and it became part of everyone's behaviour to accept tips even though it could lead to imprisonment: "Tipping was something very universal in this country." (R7 Policy-maker)

So, in order not to choose between having a better life and being afraid of going to jail, people "pretend" to work and consumers "pretend" to pay (R1 Nurse Leader). Participants developed the argument that cash payments from patients to providers prohibit equal access within the formal and informal health economy.

Within this harsh and dual society Romanian nurses struggle to survive on an average net maximum wage of €250 per month (CAI, 2006). Interviewees stress that nurses involved in supporting the health-care system in Romania have to be very motivated and dedicated in order to be able to provide nursing care under appalling conditions. Nurses are obliged to work 18-hour

shifts, sometimes taking up to three shifts in a row just to earn a basic salary which prevents them living below the poverty level (R16 Policy-maker; R3 Nurse Leader; R5 Nurse Leader).

> "Nurses' salaries are very low compared with other countries' salaries, so nurses will go to other European countries. And I know they have already gone to other countries, which makes things very difficult in Romanian hospitals." (R16 Policy-maker)

A duality exists as there is high unemployment amongst nurses (up to 50%) on the one hand while at the same time there is a shortage of nurses in nursing units. The dichotomy shortage/unemployment results from freezing posts due to austerity measures (R3 Nurse Leader). Consequently, most participants noted that the poor working conditions for nurses in Romania impacted most markedly on the mobility of nurses to western European countries. Nursing leaders entering accession negotiations acknowledged the importance of their negotiated outcomes on the mobility of the nursing workforce within the EU. Nursing leaders are aware of this tension in which compliance with the European Nursing Directive (i.e. moving nursing education from secondary to higher education level) implies losing the nursing workforce to the West. This pushes Romanian policy-makers and nursing leaders to argue that the best way to prevent nurses leaving Romania is to keep them at the lowest educational level.

Most interviewees agree that the Communist regime in Romania downgraded the nursing profession by moving the entire nursing workforce to a secondary-level education. Thus, prior to EU accession, nurses took the role of medical assistants within a health-care system (still the Soviet Semashko model) in which not every health-care user had the right to dignity, information, access to services, choice, safety, privacy, confidentiality, comfort, continuity and opinion (R13 Civil Society Advocate). As described by a Romanian parliamentarian who is also a nurse:

> "We cannot succeed in changing mentalities in labour, in politics, regarding respect for each other, respect for values as we lost all these during the Communist regime. Now it is very difficult to reconstruct all these. And for this reason we have some tendency of a 'dictatorial' attitude, of corruption, of not to recognise and respect the values. We still have new politicians who are very interested to make money, to create groups of interests, at the high level in politics." (R19 Nurse Leader/Politician)

Similar views are expressed by an advocacy member of the health NGOs:

> "Our health system is a disaster, with or without doctors. Nobody who has been hospitalised in Romania in a state-run hospital can say that they didn't pay under the table to the doctor, the nurse. It is part of our culture to pay extras for being better taken care of. You could be the last one being taken care of if you don't pay." (R13 Civil Society Advocate)

Interviewees highlight that patients' rights are not protected in Romania. Romanian law on patient rights aims at doing this but has not been implemented (R4 Politician; R9 Nurse Leader).

After working conditions impacting on legislative development, most interviewees identified medical domination of nursing and the health-care system to be the main barrier for nursing leaders seeking to influence the EU accession policy process.

6.1.6 Medical domination

Participants indicate that physicians were not afraid to take up Communist Party positions to advance their careers and thus became part of the system of control and fear (R3 Nurse Leader; R6 Nurse Leader). "Nurses kept on being afraid of losing their jobs, being obliged to obey, and doing their jobs as they are told" (R11 Nurse Leader/Policy-maker).

Consequently, most interviewees express their concern over the difficulty of addressing professional autonomy for nurses in Romania, since most policy-making positions are taken by physicians. Several participants raise concerns about the position of nurses versus physicians, indicating the need for:

> "Sufficient capacity to express and expose themselves as a profession, to develop an organisational culture, an organisation with a clear message to influence the medical profession with sufficient strength and power." (R8 Policy-maker)

Thus, standing up for nurses and nursing as an independent profession remains one of the most important challenges for nursing leaders in Romania.

As a consequence of the Communist regime, physicians in Romania consider it part of their traditional role to formulate nursing education policy, and therefore nurses have always been under the authority of physicians. Interviewees indicated that:

> "the medical profession maintained nurse assistants at their disposal by creating a scenario of pushing themselves forward which made it more difficult for nurses, as a profession, to stand up for themselves" (R5 Nurse Leader; R4 Politician).

Nevertheless, participants equally expressed their view that "nurses accepted their role as technicians, executing only what the doctor told them to do" (R4 Politician).

It is within this context that the work of nurses became undervalued in society. A number of participants indicate that this was because nurses were considered to be only "the executors of physicians' orders", "the handmaidens of doctors", and "the auxiliary staff to the doctor without any decision-making power" (R1 Nurse Leader; R8 Policy-maker; R5 Nurse Leader). Some interviewees add that during the Communist regime the term 'nurse' (*infirmieri e*) became associated with a cleaning lady while 'medical assistant' (the term given to a nurse) scaled up the status of Romanian nurses to an assistant of the doctor.

The data indicate that the Romanian governmental negotiators were inexperienced policy-makers, physicians, who did not stand up for nurses and nursing and had little knowledge of designing nursing education curricula in compliance with the Directive 2005/36/EC. As expressed by one nursing leader: "The Romanian negotiators did not understand the topic ("Nursing Education") to be negotiated. The negotiator did not understand nursing education." (R1 Nurse Leader)

Some participants believe that the nursing profession holds no power and lacks unity and the strong leaders needed to push for a professional agenda. One high-ranking official states clearly that "a change in mentalities is first needed", but a physician who is also a political advisor, emphasises that "the medical profession includes doctors AND nurses", considering that "a good nurse is a person who has a lot to give ... [with] a low profile, huge action and highly effective" (R12 Physician/Policy-maker). A Romanian international policy-maker suggests:

> "Nurses should get up, hold out their hands to each other and do a lot for themselves. But start to do something. So far, they are saying 'Yes doctor, right doctor, although many times they do things that doctors do not have to interfere with or advice on." (R7 Policy-maker)

This suggests that if nurses seek change they have to make it happen by seizing the initiative.

It is within this professional context, of doctors dominating nurses, that nursing leaders entered the EU accession process. Participants describe the third barrier to nursing leaders' engagement in policy-making to be the political context.

6.1.7 Political instability

Participants indicated that many Romanians found the transition from a totalitarian regime to democracy in 1990 very difficult as most people found it hard to cope with "the new freedom". Interviewees asserted that ex-Communist politicians took advantage of the "crowds' naivety" by manipulating society and keeping the population uninformed. This situation created a political opportunity for many ex-Communists to become the "new politicians" without any planning (R8 Policy-maker; R12 Physician/Policy-maker; R12 Physician/Politician). As one Romanian informant explains:

> "Everything was possible, no rules, no establishment, no structures, nothing. So those politicians reading a lot, having international networks and willing to become politically active with a new identity, took this opportunity." (R8 Policy-maker)

Most of the Romanian politicians were therefore in a situation in which they had not been prepared for politics. Very few political figures are seen as politicians "because they were not born as a politician" (R12 Physician/Politician). This interviewee, being both a politician and a physician, continues:

> "this generation of politicians entering EU negotiations have not been trained to do this job, they just learned by doing it, with all the imperfections and lack the abilities, skills to be more efficient and effective as politicians" (R12 Physician/Politician).

Similarly, a nursing leader said: "It was not my intention to become a political person, it just happened." (R19 Nurse Leader/Politician)

Participants further underlined that Romanian policy-makers designed policies according to the "whims of politicians", and they are "very top-down, hierarchical and bureaucratic" (R12 Physician/Politician; R7 Policy-maker; R12 Physician/Policy-maker). Participants built the argument that "very few politicians from eastern Europe would be able to win elections in the West" (R12 Physician/Politician). Most participants considered all political parties in Romania to be very weak, comprising politicians who citizens mainly perceive as: "much more interested in

getting to government and sharing their spoils of government and enriching their arsenal of friends by creating laws which concord with their personal interests and benefits" (R12 Physician/Politician; R1 Nurse Leader), instead of governing the country for the benefit of its people who suffered under an extreme totalitarian regime prior to 1990.

The interviews with nursing leaders and civil society advocates show clearly their suspicions of Romanian politicians driven by self-interest and making laws according to their personal interests and benefits. A political informant contributing to the study interviews believes that:

> "the fights between political parties and the existence of the secret service represent a toxic combination and prevents [Romania] developing [as] a very strong country and political voice ... we still have many and new incoming politicians who are very interested to make money, to create groups of interests, at the highest political level. They are mainly doctors and they make the politics for their own interest." (R19 Nurse Leader/Politician)

Participants stress that the implication of ambitious doctors and self-interested politicians in positions of influence is that the nursing agenda is totally overlooked when designing policies. Some accounts make it clear that: "internal preparations for the negotiations became a mess, although 350 civil servants were working on EU accession" (R15 Policy-maker).

Interviewees also stress that no targets or required outcomes were set before the delegation left to negotiate with European Commission civil servants in Brussels. One informant said: "...we should have set priorities. Unfortunately, we like to do things quickly and that is our main problem" (R15 Policy-maker).

These accounts reveal the political complexities of Romania – of trying to adapt to democratic processes in principle whilst the overall culture of operating in accordance with vested interests inherited from the former Soviet system remains intact.

Most interviewees argued that the residual problem of corruption remains one of the main challenges in Romanian politics as norms of behaviour have changed little post revolution (R9 Nurse Leader; R10 Nurse Leader; R15 Policy-maker; R1 Nurse Leader).

> "The civil servants in the ministry or other state authorities start adopting the same behaviour as their bosses. So, if you have a good minister, you will see that people are willing to do their job properly. Instead, if they see that their bosses do nothing and get paid really well, then they all move towards doing nothing". (R13 Policy-maker)

Consequently, participants expressed their hopes that Romania would manage to develop "a stable political system" with a more consolidated political party arena when entering the EU pre-accession negotiations.

> "We Romanians are coming from another system, with other rules, with other mentalities, with other ways of thinking, of being less educated, of being lied to, not dealing with reality, not finding our instruments or being able to be pro-active. All the time, there was someone else who was saying: 'Do it this way'." (R16 Policy-maker)

6.1.8 Summary

The analysis of the interviews identified four specific contextual factors making nursing leaders more prepared to enter the EU accession process: (i) living through a totalitarian regime; (ii) double identity; (iii) existing networks, networks and leadership; and (iv) civil society advocacy.

In other words – if you can survive a totalitarian regime, you can survive anything. It is therefore argued that the nursing leadership engagement with EU accession relied on the behaviour and skills developed and acquired during the pre-democratic regime. Being well-prepared for entering EU accession came from developing 'extra sensors' to survive in a political and health-care system in which nobody could be trusted. Due to the constraints of the Communist regime, nursing leaders became more attentive and vigilant and developed their skills to operate in the political and health-care system. Interviewees report that this implies never saying no to a political request and showing appreciation and recognition for their political leaders. At the same time nurses excused themselves by saying how busy they were and the difficulty of escaping from getting involved in the Communist Party. This enabled the nurses to retain their professional and holistic values and beliefs that kept them in nursing. Resistance is clearly an important feature of leadership and, as this chapter has indicated, nurses and others retained their critical sensibility despite the tremendous human risk involved in rebelling.

This situation helped the development of international experience (a hallmark of leaders) in order to avoid being cut off from the rest of the world. Interrogations on return were part of this process, but networking with role models in nursing at national and international level enabled the development of leadership skills and capabilities. The networks of independent-minded individuals kept nurse leaders energised and motivated to change nursing education and the profession. Most interviewees therefore believe that Romanian nursing leaders were prepared to enter the EU accession process and influence its policy process.

Following on from the indicators facilitating policy influence, the analysis indicated three main barriers to the nursing leadership's impactful engagement in the EU accession policy process: (i) the Soviet Semashko working environment; (ii) medical domination; and (iii) the unstable political system. Romania nominates a new health minister every year and it appears that only physicians are eligible for this post in a mainly doctor dominated policy environment in which nurses are marginalised. Consequently, the name ‘nurse assistant’ is being used instead of ‘nurse’. Furthermore, political instability and the appointment of politicians lacking any preparation for their role reveals the political intricacies of Romania – introducing adaptation to democratic processes in principle whilst the overall culture of operating in accordance with vested interests inherited from the former Soviet system remained intact prior to EU accession.

It is within this professional, economic and political context that nursing leaders entered the EU accession policy process. It is also against this contextual background that the achieved outcomes of the EU accession process should be interpreted.

Prior to evaluating the legislative and professional outcomes, it is important to explore the processes and mechanisms through which nurse leaders engaged specifically with the *Acquis* (second study objective).

6.2 Agenda-setting mechanisms for engagement in the EU accession process

Three processes and mechanisms were available to the Romanian nursing leadership to enable it to engage with the *Acquis*: the Commission's comprehensive monitoring reports based on the TAIEX peer review reports and the TAIEX capacity-building seminars. Although available within the EU accession process, neither the Romanian government nor civil society stakeholders (including nursing stakeholders) applied for capacity-building seminars; the government saw no necessity as it considered that compliance had already been achieved. In addition to these three identified Commission mechanisms for influencing policy development, participants identified the Romanian emergency ordinances as a mechanism that stopped the nursing leaders' engagement in the EU accession process.

6.2.1 European Commission's comprehensive monitoring system

During the Luxembourg European Council (December 1997), heads of state from 15 EU MS set February 2000 as the official start for Romania's membership negotiations with the European Commission.

Within this political agreement, acceding countries need to comply with the political prerequisites – stability of national institutions guaranteeing democracy, the rule of law, human rights and freedom of expression – and to transform their national economy into a functioning single market economy with the free movement of goods, persons, services and capital.

The European institutions overseeing the EU accession process (European Commission, European Parliament, Council of Ministers) evaluate progress towards achieving the economic and political prerequisites for EU accession, verify compliance and take political decisions based on the Commission's comprehensive monitoring reports (European Commission, 1998, 1999, 2000, 2001, 2002, 2003, 2004).

One sentence in the *Comprehensive Monitoring Report 2002* said: “no progress was made on mutual recognition for the sectoral professions” (European Commission, 2002). This was politically powerful enough to make the Romanian government aware of the consequences of non-compliance with Directive 2005/36/EC. Consequently, halfway through the EU accession process (June 2004) the European institutions agreed to set a safeguard clause for Romania.

This increased the political pressure by delaying entry to the EU by one year if the Romanian government failed to meet the political and economic targets (European Commission, 2004). Furthermore, the *Comprehensive Monitoring Report 2004* stated that, although Romania had achieved stability of institutions guaranteeing democracy and the rule of law, the public administration: "is still characterised by cumbersome procedures, a lack of professionalism, inadequate remuneration and poor management of human resources" (European Commission 2004).

Nevertheless, it can equally be argued that, as a mechanism to evaluate progress, the comprehensive monitoring reports do not have enough clout to move from legislative endorsement to legislative implementation through governmental commitment. As expressed by one participant policy-maker:

> "There are extraordinary democratic laws which have to be implemented by people who do not understand the value and the meaning of those principles of the rule of law." (R16 Policy-maker)

She continued:

> "There is a substantial need for training the people to change their mentality, because if you start to assess, to understand what is happening from the top of the hierarchy to the bottom of society, you will see that this pyramid is not working democratically." (R16 Policy-maker)

This implies that the government's failure to opt for a stakeholder approach to inform and guide policy design had caused participants to be sceptical of their compliance from the outset of negotiations.

Two months after European political leaders agreed the *Comprehensive Monitoring Report 2004* all chapters of the *Acquis* were provisionally closed – including Chapter 3 containing Directive 2005/36/EC. The Romanian government's lack of policy efforts to upgrade nursing education prior to EU accession is reflected in the Directive derogation. Although Romanian nurses fall under the automatic recognition system, they must meet one of two criteria, depending on the education followed (Article 33):

- Nurses whose education started after 2007 – after Romania's accession to the EU – are directly recognised by presenting the diploma that appears in Annex V.
- Nurses whose education started before 2007 have to prove five years of professional experience in the last seven years in addition to their title.

Instead of upgrading nursing education for the entire existing nursing workforce, the Romanian government accepted this derogation implying Romanian medical assistants being subject to the supplementary conditions for the recognition in other MS of their professional qualifications of nurse responsible for general care. Although the 2002 and 2004 TAIEX peer review reports provided evidence of the areas requiring further strengthening to achieve full compliance for the entire nursing workforce, the comprehensive monitoring reports did not take these recommendations into the EU accession political debate in the Council and European Parliament. In order to be able to close Chapter 3 of the *Acquis*, the Romanian government agreed to install nursing education at university level from 2007 onwards.

6.2.2 European Commission's TAIEX peer review mechanism

TAIEX provides the technical assistance to develop the administrative infrastructure and capacity to ensure full implementation of the *Acquis*. The compliance policy process in Romania was supported by TAIEX peer reviews – the 2002 and 2004 peer review reports pinpointed areas that require further strengthening and were important sources of information for the comprehensive monitoring reports on which political leaders from the European Commission, the European Council and the European Parliament made informed decisions on compliance with the *Acquis*.

Coordinated by the TAIEX unit of the Directorate General (DG) for Enlargement, the peer review involved the full participation of the Romanian Ministry of European Integration, the Commission Enlargement Unit and appointed experts. The Romanian government agreed to the evaluation process in advance and provided full support to the peer review. This team for Romania included a group of highly experienced nursing experts from the Netherlands, Sweden, the UK and Belgium.

Appointed by DG Enlargement, based on their experience gained from previous peer reviews, these experts met in Brussels for a briefing and to discuss with the Commission the detailed aims of the mission. These included the benchmarks to be used and procedural issues such as the composition of the team, duration of the mission and time schedule. The contract included a daily

allowance of €250 for each overnight stay required, together with a fixed additional allowance of €250 per working day and effective travel day.

The main foundation of the mission was a factual questionnaire, a checklist to enable an evaluation that was efficient, objective, consistent and comparable. The agreed questionnaire was sent to the Romanian government for completion and return in advance of the evaluation visit in order to allow both sides adequate preparation. Although many documents were received, most did not accurately reflect the current state of the transposition process.

The programme and evaluation mission time-frame was agreed to be one week. The programme included discussions with all relevant stakeholders (i.e. competent ministries, local authorities, enforcement bodies, chambers) and visits to observe implementation arrangements on the ground. The last day of the mission was used for a debriefing of the evaluation team and drafting a concise and operational report describing the current situation of compliance with Directive 2005/36/EC.

The Romanian government had the opportunity to make factual remarks on the report before it was finalised and agreed by the Commission services. The final report remains the property of the Commission services with a copy sent to the Ministry of European Integration. As I was appointed for the 2004 mission, my contacts allowed me to track the implementation of the recommendations.

Although the TAIEX peer reviews addressed numerous concerns, these legislative and professional concerns formulated by the experts (including myself in 2004) were not picked up in the Commission's comprehensive monitoring reports. The Comprehensive Monitoring Report in September 2006 concluded that: “Romania will be in a position to take on the rights and obligations of EU membership on 1 January 2007” (European Commission, 2006). It is important to benchmark the TAIEX peer review recommendations in order to have a clear view on the achieved legislative outcomes (see section 5.4.1.1).

6.2.3 Failure to undertake TAIEX capacity-building seminars

TAIEX capacity-building seminars are largely demand driven, facilitating the delivery of appropriate tailor-made expertise to address the shortcomings identified in the TAIEX peer review reports. Although the government applied these to strengthen the administrative and legal capacity of other parts of the *Acquis*, none of the Romanian stakeholders took up the option to

apply for capacity-building seminars to advance Chapter 3 compliance: bringing the nursing education leaders together to design national nursing legislation and curricula conform to Directive 2005/36 EC. TAIEX support to Romania amounted to €266.5 million in 2003 and pre-accession assistance increased to €434.3 million in 2004 and to €444.6 million in 2006. The technical assistance to achieve compliance with EU legislation focused on *Acquis* areas such as agriculture, transport (e.g. road safety legislation; restructuring process for Romanian railways), environment (e.g. radioactivity monitoring system; waste management), public finance (e.g. external audit; public procurement), home affairs (e.g. fight against organised crime; drug trafficking and abuse; police cooperation; human trafficking), justice (judicial reform) and public administration, but not for upgrading the education of nurses throughout Romania. One possible explanation is the failure to ask for capacity building seminars reflected a resistance to confronting the deficiencies of the nursing system and encouraging further questions about weaknesses that might jeopardise the case for compliance.

In relation to the Roma, 3300 teachers and 243 school inspectors and school principals participated in training programmes promoting inclusive education in Romanian schools. In economic and social cohesion, TAIEX provided assistance for the implementation of national and regional policies in human resources and social services, education, local and regional infrastructures, environmental protection at regional level and development of small and medium enterprises. It can therefore be seen that the Romanian government did not reject the use of capacity-building seminars but did not saw the education of nurses and other health professionals as an issue being a barrier for entering the EU. The attitude of the Romanian government was one of complacency and reluctance to admit to deficiencies in the system and denial that there were problems that needed addressing. Requesting funds from the EC for nursing implied admitting there is a problem to be fixed. Although only the government can apply for EU capacity-building funds, the Romanian nursing leadership did not press to apply for EU capacity-building policy support despite being very well aware of the existence of key challenges which can be addressed by these EU accession funds.

This failure to demand support that was known to be available, seems to have missed a major policy window opportunity to bring together relevant stakeholders to design new national nursing legislation in compliance with the European Directive. Perhaps one of the reasons for this failure

is that any application for capacity-building seminars would have indicated recognition of a problem with compliance.

The 2004 TAIEX report (European Commission 2004) recommendations clearly state that "facilitating the implementation of the change process will require different degrees and types of support from TAIEX" but the Romanian government believed that capacity-building seminars for nursing were not relevant for Romania's accession to the EU. There is evidence from the interviews that most politicians perceived the EU accession process "as an easy thing to do" (R15 Policy-maker; R17 Nurse Leader). Although the findings show some degree of complacency related to the compliance process and specifically to the Directive on MRPQ, ignorance rather than complacency could have an impact on the use of the Commission's mechanism to process compliance. It can even be argued that the Romanian government was well aware from EU briefings that Taiex could be used to upgrade nursing but did not care to move nursing towards becoming a profession in Romania. Perhaps what could be interpreted as complacency is in fact a fear of admitting that Romania lags behind; being too proud to say that Romania does not comply with EU specifications.

Civil servants from the Ministry of Health and the Ministry of Education explained in interviews that "My minister sees EU compliance as a minor challenge, easily manageable on our own" (R2 Nurse Leader; R8 Policy-maker). Consequently, there was no application for a structured or agreed roadmap for future technical assistance from TAIEX to address the identified legislative shortcomings and thereby ensure that Romanian nursing education met the Directive's minimum requirements. This clearly contrasted with the Croatian case study findings as set out in Chapter 6.

6.2.4 Bypassing democracy

In order to speed up the legislative compliance negotiations with the European Commission, emergency ordinances were used as a political mechanism to pass laws, specifically Law 461/2002 (Romania, 2002) and Law 307/2004 (Romania, 2004) setting out the regulation of the nursing profession in Romania (Appendix 7). Emergency ordinances are mechanisms available to the Romanian government without the need to refer to the normal parliamentary processes. The use of such tools is an indication of the extent to which the government, rather than the parliament, was making decisions about nursing legislation. Consequently,

parliamentarians and the nursing leadership were excluded from engaging with the design of new Romanian nursing legislation in compliance with the EU Directive prior to EU accession. Only the government leading the negotiations was involved in the design.

Interviewees asserted that many, if not most, of these emergency ordinances cannot be justified from the standpoint of their 'emergency' nature. One informant in particular reported that the Romanian government's main interest was to move forward quickly as it perceived the whole accession process to be "an easy thing to do as most Romanian legislation complied anyway with EU legislation (the *Acquis*)". This is debatable, even among participants who indicated that this might have been fuelled by the government's over-optimistic view of the limits of its own powers, legality and maturity to move compliance forward.

Moreover, the interviews indicate that this policy context was facilitated by having:

> "Very weak political parties, much more interested in getting to government and sharing the spoils of government, not really interested in how to use government, apart from enriching their arsenal of friends." (R4 Politician)

This is quite an important statement, revealing that most Romanian politicians did not see nurses and nursing as a potential voting power as the different nursing constituencies – the regulator, the union and the professional association – have conflicting agendas on the upgrading of the training of Romanian medical assistants (Romanian nurses). This leaves the largest health workforce section unorganised and divided. Although it is not uncommon for unions, professional associations and regulators to have different "public" stances, the conflicting views undermined efforts to present a united front to policy-makers.

In contrast, the data also show that most nursing leaders opposed the government's lack of action and engagement. Interviewees stressed that nursing stakeholders:

> "Couldn't stay any longer in the shadows and that they had to get involved to be able to change the mind-set of communism to democracy. Therefore, moving from the Faculty of Psychology and Sociology to the Ministry of Education Inspectorate enabled them to have the EU Directive and the Romanian law at hand to be more active in setting the Romanian standards according to the EU".

This determination to act was shared amongst most nursing community leaders in Romania who wanted to seize the opportunity to raise the status of the nursing profession during accession to the EU. For example, nursing academics from other university faculties actively pursued direct contact with the Ministry of Education in order to create opportunities to shape and influence the policy process agenda and the RNA advocated publicly for change.

Furthermore, other nursing leaders met senators to confront them with different, even conflicting views in order to challenge the governmental perspective “to take it the easiest way” (R5 Nurse Leader). These conflicting views relate mainly to upgrading nursing education from secondary level to higher and even university level. An informant admitted that “each national member of the Parliament has his/her own idea on the obligations of Romania to harmonise national legislation with the *Acquis Communautaire*” (R17 Nurse Leader).

6.2.5 Summary

The mechanisms by which nursing leaders could engage in the EU accession policy process were limited to one Commission instrument – the TAIEX peer review reports. The nursing leadership had no possibility of influencing the comprehensive monitoring reports and did not use the opportunity to apply for EU funds for capacity-building seminars to build awareness of the implementation of the Directive 2005/36/EC requirements.

Within the Commission's comprehensive monitoring reports the main emphasis is on the administrative and judiciary capacity to implement the *Acquis* and on the economic reform, therefore compliance with the Directive on MRPQ is not sufficiently picked up politically at either national or European level. These reports make limited reference to the recommendations set out in the TAIEX peer review reports and so nursing education is less political than other sectors such as agriculture, environment, judicial reform, public administration and Roma.

Furthermore, the TAIEX peer review reports are treated as a negotiation tool between the government and the Commission, with minor engagement of the nursing leadership to formulate solutions to address the weaknesses as addressed in these reports. These relate to lack of focus and teaching in the nursing curriculum and the medical profession's continued dominance over nurses.

The nursing education weaknesses identified in the TAIEX peer review reports are not addressed through the application process for TAIEX capacity-building seminars as the Romanian government's lack of readiness and complacent attitude prevented upgrading of the entire nursing workforce in Romania. In order to circumnavigate these problems the government used emergency ordinances as a mechanism to bypass parliamentary legislative process in order to override democratic policy-making and to speed up the compliance negotiations with the European Commission.

Based on these process findings, the legislative and professional outcomes are now evaluated.

6.3 Impact of EU accession policy process

Based on the identified contextual indicators and the mechanisms available to the nursing leadership for engagement in the EU accession policy process, the legislative outcomes are explained.

The nursing leadership remains imbued by the culture of the Communist regime in which nurse leaders' interests, their patterns of interactions and conflicting roles in policy design set the level of compliance with European Directive 2005/36/EC. Although by 2004, Communism had ceased to prevail politically for fourteen years, the cultural legacy persisted. Specifically, nurse leaders were brought up during Communism, some of whom were engaged in the polite bureau prior to 1990 and continued to support keeping nursing at sanitary and secondary level, although there was a strong strand of opinion supporting the development of nursing as a profession by implementing the Directive 2005/36/EC.

The data provide evidence of diverging and contrasting views based on different interests and powers identified between stakeholders.

6.3.1 Legislative compliance

On 14 December 2004, Romania provisionally completed all negotiations on compliance with EU legislation, including Chapter 3 in which the Directive on MRPQ is located. With the closure of Chapter 3 the Romanian government and the European Commission are of the opinion that the provisions of Directive 2005/36/EC on the exercise of the profession of nurse responsible for

general care are integrated in Government Emergency Order No 144/2008, amending Law No 461/2001.

6.3.1.1 Benchmarking the minimum requirements of Directive 2005/36/EC

Analysis of the three TAIEX peer review reports (European Commission 2002, 2003, 2004), reveals that the TAIEX nursing experts and the Romanian government held different views on compliance with Directive 2005/36/EC. These diverging views relate to the Directive's minimum requirements as discussed below.

1. A minimum entry level of 10 years of general education. In 2000, students entered the nursing programme at 15-years-old; by 2004 entrants were at least 17/18-years-old. These findings are supported by some interviewees who express their concern that applicants "in secondary school are too young to choose nursing as a future profession" (R2 Nurse Leader).
2. Meeting a full educational programme of 4600 hours of which one third of the educational programme must be theoretical and at least one half must be clinical training on a full-time basis: 2238 hours of theoretical instruction and 2460 hours of clinical instruction. The nursing curriculum was not explicitly nursing focused and the clinical evaluation was done by physicians.
3. The nursing curriculum includes at least the programme as described in Directive Annex 5.2.1. Concerning compliance with Annexe V of the Directive, the Romanian authorities were not willing to change the title 'medical assistant for general care' to 'nurse in general care'. Most nursing leaders were resistant to the legislative reinstatement of the title 'nurse' (*nursă*) or 'infirmier(re)' (*infirmieră*) rather than the currently used title 'medical assistant'. This was because infirmier was used during the Communist period for workers with domestic duties. Medical assistant was preferred because it emphasised the technical and medical aspects of nursing, leading to a better professional status and hence invested with the hope of increasing standards and recognition. In contrast, the TAIEX experts appointed by the Commission argued the necessity of using the term 'nurse' and designating the activity as 'nursing care' (both emphasised in the Commission reports) as the term 'care' (*a îngriji*) was not specific enough.

The TAIEX peer review (TAIEX, 2004) identified the implementation of Article 31 of Directive 2005/36/EC – the role of nurses responsible for the planning, delivery and evaluation of nursing care – as the main challenge after the process to assess the skills and knowledge of nurses.

During the review the clinical instruction programme was discussed with peers and government officials, mainly the Ministry of Education and the Ministry of Health, recognising the medical domination of the nursing care process. This programme was generally not in line with the requirements of the Directive. Although a qualified nurse guides nursing students during clinical instruction, their technical skills for specific procedures are eventually assessed and signed off by a physician.

Consequently, clinical instruction focused very much on instrumental procedures while an integrated nursing approach seemed less relevant for all nursing interventions. Nurses in Romania are still called medical assistants, making free movement based on mutual recognition of professional qualifications more difficult for Romanian nurses.

Compliance with the Directive was questioned further as it was not clear whether nursing students were monitored by college teaching staff and were the responsibility of the colleges during the summer clinical placement and during night shifts. If these hours were not recognised as a part of the programme for nurses responsible for general care, the total study year of the colleges would consist of only 36 weeks. In 2004, clinical training in universities was led by physicians and no programmes were led by nurses. All of the individuals who taught at the nursing colleges held a master's degree, in a range of disciplines except nursing.

Having assessed teaching topics and clinical placements, the TAIEX peer review examined the lines of accountability and responsibility between the nursing regulator (*Ordinului Asistenţilor Medicali Generalişti*), the nurses' trade union (Sanitas), the professional nursing organisation and the Ministry of Health. The nursing regulator was established following the 2002 TAIEX recommendations but it was not until after the 2004 TAIEX mission that amended Law No. 307 ensured clearer lines of accountability and set out the roles and different responsibilities of different nursing posts (Appendix 7). Thus, the EU accession process impacted on the development of the nursing regulator. This law 307 also transferred the register to the newly established Order of Nurses, Midwives and Medical Assistants in Romania (OAMMR - *Ordinului Asistenţilor Medicali Generalişti*). Although the OAMMR has the disciplinary authority, in 2004 no

professional standards had been developed for the guidance of disciplinary measures. Furthermore, this newly developed law did not do justice to the profession of nursing as some articles (e.g. 20, 21 and 33.1b) harmed and hindered the development of nursing as an independent profession within the Romanian health-care system.

Finally, through the TAIEX recommendations, EU accession led to the creation of the post of Chief Nursing Officer (CNO) within the Ministry of Health in 2005. However, the lines of accountability and responsibility between the OAMMR and the Ministry of Health were not followed through. This implies the TAIEX mechanisms are mainly focussing on 'legal' compliance while effective implementation is beyond the scope of the Acquis implementation. The conflict of interest when occupying two important policy posts, the CNO and the president of the regulator, remains unresolved and creates lack of policy transparency which became a barrier to build trust between policy stakeholders. The relationships between the leaderships of the relevant professional and trade union organisations, the OAMMR and the CNO need to be clarified and strengthened if they are to contribute effectively to the national and EU-wide policy process. The lack of accountability and follow through from the Taiex process may also reflect inherent weaknesses within the structure of Taiex as a policy instrument.

6.3.1.2 Institutional rivalry

The Romanian government interpreted compliance with the European Directive on MRPQ as a need to develop new institutional structures for the recognition process – to create stable institutions and guarantee democracy and the rule of law by strengthening judicial and administrative capacities and resources. As such, the Romanian government responded by establishing new governmental departments, each responsible for a specific task within the process of mutual recognition of professional qualifications. Interviews confirm that the "Ministry of Education and Ministry of Health were found weakened after 1990" (R1 Nurse Leader; R5 Nurse Leader) leading different aspects of the accreditation process of mutual recognition of professional qualifications. As such, the Romanian government created next to the Council for Occupational Standards and Attestation (COSA), being the 'autonomous' body ensuring transparency of the vocational qualifications, the National Centre for Recognition and Equivalence of Diplomas (CNRED) being the national co-ordinator for the general system of recognition, located within the Ministry of Education.

Most Romanian nurses who qualified under the former Communist regime do not comply with the Directive's minimum criteria and lack the experience required under the general system (on a case-by-case basis, not mutual recognition of professional qualifications), therefore CNRED held an important portfolio within the negotiations. In a situation of political tension between the Ministry of Education and the Ministry of Health, the Romanian government granted the Ministry of Health's request to create the 'Service for Recognition of Professional Qualifications and Continuous Training of Health Professions' with the main task of recognising the qualifications of doctors, dentists, pharmacists, nurses and midwives.

It can therefore be interpreted that the Ministry of Health, in alliance with OAMMR, used the EU accession as a policy window opportunity. The Ministry of Health foots the final healthcare bill while the Ministry of Education is more concerned about access to a profession and the accreditation of systems, both of which could lead to opposing views and tensions. The Ministry of Health owns more of the portfolio and its allocated budget while the Ministry of Education is oriented more towards the higher education sector. Upgrading nursing education towards higher education implies the Ministry of Health losing its budget for vocational training.

It can be argued that the rivalry over responsibility for the recognition of credentials within the Ministries reflects the tensions between the nursing profession bodies so as to maintain its own control over the professional development and the co-ordination of the EU accession activities.

6.3.2 Professional achievements

In addition to the legislative compliance with EU legislation, the Directive on MRPQ can boost professional development based on article 31 of the Directive 2005/36/EC. Themes such as 'EU as lever for policy reform', 'holding on to a sanitary vision', 'upgrading through bridging courses' and 'losing the nursing workforce to the West' indicate the challenges ahead.

6.3.2.1 EU as a lever for policy reform

Overall, it can be argued that the EU accession process provided a policy window opportunity for the nursing leadership – providing potential political influence and developing their advocacy and leadership capacity within the policy process. This is significant considering that only 17 years prior to EU accession the same nursing leaders operated in a system of fear and control in which mobility to EU MS was near impossible without a friend in the government to provide the necessary documents. As expressed by a high-level policy-maker in Romania:

> "Romania was one of the very enthusiastic countries towards EU accession. In the statistics, it was on the top. I think of the desire of the people to change things and the desire to develop the economic interest of people in the field to have larger markets, to sell more and to produce, while in the institutions field, civil servants wanting to develop policies and activities serving the Romanians. There was a very interesting desire to belong to the EU, to have this power of the EU to continue changing Romania, to continue the transformation of the country towards democracy." (R16 Policy-maker)

From the data presented it should be clear that the Romanian people, including nurses, are looking to use the EU as a lever to accomplish policy reforms that should bring about positive change, leading to economic prosperity and democratic rule in Romania. Consequently – in a society still partially caught up in a policy context of the Ceausescu totalitarian regime, with a strong political and economic oligarchy and widespread corruption – participants perceive EU accession as a process enabling them to move towards a more functional democracy, with the *Acquis* being transposed into the national legislation. Nevertheless, as one informant stated: "Romania has now extraordinary democratic laws which have to be implemented by people who do not understand the value and the meaning of those principles of the rule of law" (R16 Policy-maker). This is supported by the nurse/politician who emphasises that "we still need more time to change the mentality to change the model and to increase other freedom next to the freedom to travel, the freedom to express ideas" (R19 Nurse Leader/Politician).

Participants believed that "things move on with a better speed. The quality of life has improved for everybody" (R13 Civil Society Advocate). And, more importantly, according to this participant "our minds are moving on, we are now becoming better citizens". This is reflected in the fact that "people in the street are more conscious of the role of politicians" (R16 Policy-maker) and "as citizens we have a Romanian voice inside the European Parliament and the European Community" (R19 Nurse Leader/Politician). Thus, it can be argued that "the prospect of accession to the EU opens the door for a new type of political change" (R17 Nurse Leader), and therefore concluded that EU accession has brought improvements in the everyday life of Romanian citizens.

Finally, many participants considered EU accession extremely beneficial, a view supported by a nurse/politician who emphasised that nurses got a very good deal since, after Romania joined the EU, the nursing profession gained the possibility of gaining access to higher education – an alternative to the educational system for medical assistants and offering four years of training at university level (R19 Nurse Leader/Politician). The OAMMR asserts that the nursing profession can now manage itself, as established through a radical and essential change in Romanian legislation. However, this improvement in nurse education benefits only the small group of nurses gaining entry to university programmes since 2007.

6.3.2.2 Holding on to a sanitary vision

The OAMMR provides the authorisation to practice, established by Law 461/2002 based on the 2000 TAIEX mission recommendation recommending the establishment of regulation for the nursing profession in Romania. According to some Romanian nurse leader participants, Law 461/2002 did not do justice to the profession of nursing. Certain articles – 20, 21 and 33.1b – were perceived as hindering the development of an essential profession within the Romanian health-care system by continuing to apply a 'sanitary' vision and assistant role for nurses within the medical profession. Some interviewees consider that the OAMMR wants nurses to continue as medical assistants (R1 Nurse Leader; R8 Policy-maker; R5 Nurse Leader). In contrast, a nursing leader from the government said:

> "It has always been physicians saying what is important for nurses. Therefore, transposing the Directive into national legislation can lead to the empowerment of nurses and nursing. If I do not have the support of the European Commission, I couldn't do anything." (R11Nurse Leader/Policy-maker)

This indicates that some nursing leaders are keen to use the EU as a lever to accomplish broader objectives in positioning nursing more positively.

The lines of accountability and responsibility between the OAMMR, the trade union Sanitas, the RNA and the CNO at the Ministry of Health set out in Law No. 461/2002 were revised by Law No. 307/2004. Presented to the TAIEX experts during their 2004 peer review mission, the aim was to clarify the roles and lines of accountability and the roles and responsibilities of these different roles. However, policy roles are blurred further as the vice-president of the OAMMR is also the CNO in the Ministry of Health, and leaders from Sanitas are also leaders in the OAMMR. This

makes the Romanian case unique and politically complex, as in no other EU MS can the CNO and the head of the OAMMR be the same person.

> "The leaders of the OAMMR were the political leaders of union « Sanitas ». (R5 Nurse Leader)

> "It's a struggle with the OAMMR. The Order being part of the Union - some people work in Union and in the same time in the Order – it is not so easy to build a partnership with them. " (R11 Nurse Leader/Policy-maker)

Nevertheless, one informant (R17 Nurse Leader) believes that the regulator managed to include some very important points in the amended law, such as giving the OAMMR an important role as a vehicle for professional jurisdiction; control of the nursing profession and the quality of the Nursing Act; and for regulatory authority in its area of competence, registration and authorisation. Thus, it can be argued that the nursing leadership achieved more power for some nursing bodies, such as the OAMMR, but did not address the tangled web of accountability between the CNO in the Ministry of Health and the OAMMR resulting from the Communist regime in which occupying both posts was not perceived as a conflict of interest. The interviewee further stresses the OAMMR powerful position as "no nurse can exercise the profession without the approval of the Order" (R17 Nurse Leader).

The OAMMR realises the impact that emigrating nurses (R1 Nurse Leader; R17 Nurse Leader) would have on domestic supply and the health system. However, some interviewees believe that the responsibility for this does not lie with the regulator but rather with the Ministry of Education in its capacity as controller of school accreditation and the curricula. One participant argued further that:

> "The Ministry of Education did not do their job well as the clinical practice/training in the hospital setting is absolutely insufficient. There are too many students, not enough spaces, insufficient supervision and no clear documents to validate the clinical practice." (R17 Nurse Leader)

This suggests that the OAMMR is 'passing the buck' to the Ministry of Education, thereby stimulating their mutual rivalry.

6.3.2.3 Upgrading through bridging courses

The accounts of the RNA nursing leaders indicate that the OAMMR blocked access to the EU policy process designing national nursing laws compatible with the European Directive. According to knowledge obtained through their pan-European affiliation, the rationale for blocking the RNA's engagement in policy-making was the fear of losing power. As one informant states:

> "Les leaders de l'OAMMR sont jaloux de nous parce que nous avons une large gamme d'informations, de contacts et de relations. C'est pourquoi ils ne nous aiment pas. Ils ne peuvent pas pénétrer ces réseaux, mais ils refusent également de dialoguer avec nous, et de négocier." (R5 Nurse Leader)

In her interview, Gabriella Bocec (RNA President who passed away during the accession period) reported the major issue of policy and political control by the OAMMR blocking any development of the RNA:

> "The continuous struggle with the Nursing Order as being part of the Union. Developing a partnership with the regulator is extremely difficult as they have the financial resources (mandatory membership) while the association depends on voluntary work." (R3 Nurse Leader)

The nurse in government (R19 Nurse Leader/Politician) confirmed that:

> "the fight between the Association (RNA) and the Chamber (OAMMR), strongly linked with the top of the trade union Sanitas, relates to keeping the power so they do not need to recognise that nursing is a profession, because that means learning more, being more educated, to learn how to make a diagnosis, how to plan a care plan for the patient. You must be very well educated, you must be more than a helper of the doctor."

She continued:

> "I had lots of discussions many years ago with some colleagues from Sanitas and now that I'm a politician, I have come to the conclusion that nothing changed as the leaders of these bodies stayed the same as during Communism." (R19 Nurse Leader/Politician)

Based on these findings, the RNA acted on its own to set the agenda, while the OAMMR, simultaneously occupying the post of CNO, together with a friend of the former Communist regime polit bureau running Sanitas prior EU accession (ended up in prison after EU accession due to corruption), dominated the information flow and access to the EU accession negotiation process.

In contrast, the RNA leaders have the ultimate aim of setting the policy agenda for upgrading education through bridging courses, creating the legislative basis for strengthening the autonomy of the nursing profession in Romania. Initially, the RNA was not in a position to seize the window of opportunity provided by EU accession as the power differentials within the nursing community stakeholders (mainly the OAMMR and the RNA) were too great and too conflicting. Consequently, advice during the compliance negotiations was provided mainly by civil servants opposed to the upgrading of Romanian nursing education, while the RNA continued to advocate loudly for nursing education for all nurses in Romania to be upgraded towards the EU standard set out in Directive 2005/36/EC.

> "Nursing in Romania does not have enough capacity to express itself as a profession. It is not bad to fight – it gives you power to understand and to take care of the future, but it is not the right time for this." (R12, Physician/ Policy-maker)

> "They have a good message, but they are not able to put on air this message, in the right direction with the right volume…." (R12, Physician/ Policy-maker)

6.3.2.4 Losing the nursing workforce

Documentary analysis indicates that, throughout the accession negotiation process, the government remained convinced that existing Romanian law regarding the practice of the profession of nurses responsible for general care was already harmonised with Community legislation. Hence, it was not perceived to be an obstacle for Romania's accession to the EU (R2 Nurse Leader; R8 Policy-maker): "On health we solved the red lights, but on agriculture and justice, it was very difficult." (R15 Policy-maker)

The Romanian government's interpretation and view of the EU agenda and requirements related mainly to its interest in keeping the nursing workforce at the lowest educational level, arguing that more Romanian nurses would be lost through migration if their education was upgraded to European standards.

> "Now we have the documents to prepare for nurses that want to work in an EU Member State. Many files of applicants need to be prepared and we are getting overworked. In one year I prepared 4000 signed documents. I'm sure they left Romania, mainly for Italy. " (R14 Nurse Civil Servant)

Interestingly, the Romanian government considers that the Romanian Nursing Act's compliance with the minimum requirement of Directive 2005/36/EC will lead to the nursing workforce being lost to 'old' EU MS such as Italy, France, Germany, Belgium and the UK. This fear was articulated by many interviewees, mainly the RNA leaders and some civil servants from the Ministry of Health. However, this view is not supported by participants recruited from the OAMMR as they argue that nobody can stop these nurses leaving Romania anyway.

Recent studies such as PROMeTHEUS (European Observatory, 2011) and ProfMob (IOM, 2011) provide evidence that this is a valid fear. European Commission IMI data (European Commission, 2011) indicate that 4239 Romanian nurses left the Romanian health system between 2007 and 2010, migrating mainly to Belgium (90), Germany (96), Italy (2581) and the UK (1284). Compared to other EU MS, Romania is the second largest source of nurses for free movement. Between 2007 and 2010 a total of 22 647 nurses moved freely, the highest numbers leaving from Germany (4540), Romania (4239) and France (2271). In contrast, the IMI data show that only 5 nurses moved from another EU MS to Romania (4 from Hungary, 1 from Latvia).

These findings confirm that the mobility fear featured prominently in the Romanian policy-makers' mind possibly leading to policy interventions designed to keep nurses within the country. As most interviewees perceived the recognition of nurses' vocational training to be important for the purposes of recognition through the general system, acknowledging that the Romanian nurses who graduated prior to EU accession are not "EU nurses" and so have less chance of leaving Romania as a qualified and recognised nurse.

> "Everybody wants university level which makes the nursing profession very attractive; they all want to have a university level qualification so they can leave Romania immediately. Therefore, I support the vocational school; you need nurses to work in practice. It is important that vocational training is recognised. They can be recognised through the general system (but then they are not nurses) to keep them in Romania." (R15 Policy-maker)

Furthermore, informal data from the UK Nursing and Midwifery Council (NMC) showed that for the last 3 calendar years most Romanian medical assistants moved through the general system (373 in 2012; 618 in 2011 and 340 in 2010) while only 103 medical assistants moved through automatic recognition in 2012, 85 in 2011 and 25 in 2010. It can therefore be argued that the excuse for not upgrading the nursing workforce as not to lose nurses to the West becomes invalid. Even when medical assistants are not higher educated, they leave Romania anyway.

Furthermore, some participants argued that upgrading the entire Romanian nursing education system towards the European Directive minimum requirements would pose an immediate threat to the Romanian health-care system as the government believed that Romanian nurses, mainly women, would leave Romania to work in other EU MS offering better working conditions and higher salaries. Civil society participants went even further in their argument and stressed that nurses would leave Romania "to do something more meaningful in life" (R18 Civil Society Activist). These views are confirmed by Commission mobility data of 2012 benchmarked with National register data. 81 medical assistants moved in 2012 through system of automatic recognition while 373 medical assistants were registered in the UK. For 2011, numbers are even higher with 54 Romanian nurses' benefiting from automatic recognition while 618 moved to the UK through the general system, meaning these medical assistants are not working as a nurses. For 2010, the UK observed a similar trend with 23 Romanian medical assistants enjoying automatic recognition although 340 moved through the general system. Based on these data, it can be argued that the Romanian government argument to keep Romanian nurses in Romania is irrelevant as they move anyway, through the general system, regardless mutual recognition of their professional qualifications.

Back to the analysis of the interviews, a physician informant also mentioned that, even when mutual recognition of professional qualifications applies, Romanians find it difficult to find a job in another EU MS. Stigma has an important impact on the mobility of Romanian citizens. Based on the experience of the accession negotiations it is argued that:

> "Although TV and newspapers says they need more doctors, they asked me first where I was from! This is stigma! The info from France and the UK that Romanian doctors are not well prepared, this is stigma! We have mutual recognition on paper, BUT in reality we Romanians are confronted with stigma!" (R15 Policy-maker)

This interviewee believes that:

> "Romania is not well regarded as a new EU Member State as there is still the stigma on being a Roma citizen, referring to being 'a gipsy'. It is sad to be a Romanian. You do not feel comfortable in your own skin." (R15 Policy-maker)

The interview data do not indicate the extent of this sense of discrimination amongst Romanians as not all participants commented on this. However, this lack of reporting is likely due to the fact that other interviewees have not pursued employment in other MS and therefore have not experienced this sense of discrimination.

6.3.2.5 Better working conditions

Alongside the nursing regulator (OAMMR) developing the Romanian Nursing Act during EU accession, the Romanian Nursing Union is identified as another policy stakeholder that was not directly engaged in the policy-making process. The nurse/politician interviewed recognised:

> "The ongoing battle with the trade union Sanitas wanting to keep the power in their hands by not recognising nursing as a profession, because that implies moving towards a higher education for nurses, more responsibilities in planning patient care. It is easier being the helper of the doctor." (R19 Nurse Leader/Politician)

It can therefore be argued that the social dialogue partners were not involved in designing an Act in compliance with the Directive 2005/36/EC. This lack of engagement has arguably resulted in continuation of the existing system of low wages, supplemented by illegal cash payments" from patients as part of the Romanian culture (Balabanova & McKee, 2002). Although most Romanians are unhappy with the services provided by their public health system, the system as inherited from Communism continues accepting the practice of 'bribing doctors' to get proper care (INSCOP, 2013). A 2005 study conducted by the World Bank for the Romanian Health Ministry concluded that these so-called informal payments amount to around 360 million euro every year (Chereches, 2011). As one informant stated:

> "Bribesry! … You go to the nurse and you give her money to take care of you…You go to the doctor and you give him money not to kill you during an operation…Easy… Well…It usually happens that you go and ask a nurse how much the doctor wants,

and you go and ask other patients how much did they give to the nurse." (R18, Civil Society Activist)

Interviewees cannot see that this will stop unless nurses are paid an official net salary of at least €600–700 per month. This compares to a €350 net salary in 2008 which was cut by 25% in 2009 due to the financial crisis (EFN, 2011).

On the other hand, Romanian citizens will not stop giving money (an envelope) as this is part of Romanian culture. Participants believe that "it's also a psychological factor that people feel more relaxed if they say: 'oh, I gave money, they will take care of me'" (R18 Civil Society Activist).

Given the appalling working conditions of Romanian nurses, even the TAIEX experts documented their surprise that anyone would wish to train as a nurse, or even plan to occupy a leadership position, in Romania. As the workers' position is advocated mainly by the Nursing Union, a review of nurses' remuneration is needed to ensure that their monthly salary is not set at a level at which cash payments from patients become the main part of their monthly income. "The development of the professionals is not a priority in Romania. For this reason, lots of good nurses and doctors go abroad" (R19 Nurse Leader/Politician).

Yet, the civil society participants paint the most worrying picture: "the Romanian health-care system is such a disaster as it is that, with or without doctors, with or without hospitals, at this point, it's the same for a patient" (R18 Civil Society Activist).

6.3.2.6 Continuing lobbying after EU accession

Advocating change was a major challenge for the Romanian nursing leadership. Although the conflicting nursing stakeholders grew up within the same regime conditions, they have differing views on how the Romanian nursing profession should develop and differing mechanisms at their disposal to influence the policy process and outcomes. Their conflicting agendas provided mixed messages not only for politicians but also for the Romanian public. Thus, a vibrant Romanian civil society interested in health and gender was not engaged to strengthen the nursing leadership in Romania.

Nevertheless, after the 2007 enlargement date, the RNA started to challenge the Romanian government by submitting a complaint to the European Commission highlighting their main concerns with respect to the lack of nursing education reform. An important continuing concern was the lack of learning material and the failure to structure secondary nursing education to provide the necessary vocational or higher education. Furthermore, teachers have not been adequately trained. Mainly non-nurses teach in the secondary school system and there is no evidence that nurse training in these secondary schools, especially the clinical requirements in diverse settings, can deliver the practical requirements of the Directive (R3 Nurse Leader).

Following EU accession, supervision of student nurses in clinical settings as well as assessment procedures for nursing skills and knowledge remain the responsibility of physicians (R16 Policy-maker; R14 Nurse Leader). This suggests that the EU accession negotiations may be seen as purely a legislative mechanism without implementation ambitions.

Despite the Commission's negative response to their concerns, after 2007 the RNA nursing leaders continued to inform Romanian parliamentarians on their views related to the autonomy of the nursing profession; defining the scope of the nursing profession and translating it into national nursing law; responsibilities for different categories within the nursing workforce; and developing nursing sensitive indicators within the patient data record. In September 2009, Romanian parliamentarians responded by sending a new legislative proposal for medical assistants to the Romanian Senate, signed by 49 senators and deputies. Law No. 586/2009 is based on the content of Law No. 44/2008 but the order of the articles is reversed and there is an added phrase on the incompatibility of one person being simultaneously both President of the OAMMR and CNO in the Ministry of Health. The RNA's advocacy for change addressing the existing conflict of interest was picked up politically but never translated into law. The Senate's Health Committee, Legal Committee and Committee on Family and Work voted against this proposed legislation, arguing that it was the same as the existing act. The Romanian government also voted against it, leading to a notice signed by the Prime Minister. As one participant suggested:

> “Legislation is nice on paper, but implementation has not been actioned. We are still working in 2009 on our nursing legislation. What we did not do well from the beginning is much harder to fix after.” (R14 Nurse Civil Servant)

It can be argued that the act of submitting a complaint demonstrates that the EU accession process advanced the nursing leadership's skills – this had never been done before and can be considered as a courageous act within the Romanian policy context.

The evidence for this statement comes from the 2004 TAEIX peer review identifying deficiencies in the Romanian nursing education and the President of the Romanian Nurses Association addressing in 2009 a letter to the Commission, DG MARKT, outlining a breach of requirements with the Directive 2005/36/EC post EU accession. The Ministry of Health and Ministry of Education jointly replied in 2010 saying that Law 307/2004 was a transposition in conformity with the Directive 2005/36/EC.

Both Ministries confirmed that the qualification of “nurse” has not been issued in Romania and that the corresponding title is “medical general assistant”. It was argued in their reply that two levels of training in the profession of medical general assistant were notified to the EC and that both satisfied the requirements of Directive 2005/36/EC. Consequently, both Romanian authorities officially stated that the complaint made by the RNA was unfounded.

Based on this answer, DG MARKT replied to the RNA in March 2010 giving support to the Romanian government arguing that Directive 2005/36/EC was implemented in Romania by two legislative measures: the Government Decision No 1477/2003 (Government Decision) transposed the harmonised minimum training requirements, the other provisions were implemented by Government Emergency Order No 144/2008 and the organization and functioning of the Romanian Order of Nurses Responsible for General Care, Midwives, and Nurses (Government Emergency Order), stating that the Directive 2005/36/EC requirements were fully implemented, the training was in accordance with the provisions of Art 31. Furthermore, it was stated that the name "assistant medical generalist" did not create any confusion.

In relation to the professional scope of practice and some differences in professional practice across MS, the Commission evaded to be involved by saying that Directive 2005/36/EC does not list any professional activity for nurses, and therefore those could vary across MS. Both installed Romanian nursing education levels provide access to the same tasks which is not contrary to EU law allowing nurses of different educational levels to perform the same tasks. However, the Commission noticed that it was required in Romania the theoretical training to be taught (at least partially) by nurse-teachers and that the Romanian authorities need to guarantee training

programmes being available for nurse-mentors in accordance with Article 31(6d) of the Directive. The complaint made by the RNA that the recommendations of the TAIEX mission were never taken up, the Commission replied that these recommendations were never considered as binding obligations for Romanian authorities and as such the relevance of the TAIEX peer review recommendations and Taiex as a process can be questioned.

Although the continued advocacy work of the RNA post EU accession provided some evidence on the EU accession being an opportunity to develop the nursing leadership and strengthening the free movement of the Romanian nurses, it is concluded that the EU accession negotiations between the Commission and the Romanian government were a missed policy window to provide equal job opportunities for Romanian nurses within the European single market. It was only in 2013 the European Commission, Council and European Parliament forced the Romanian government to install bridging courses by including a recital in the modernised Directive stating that bridging courses using European social funds would need to be introduced.

6.3.3 Summary

Nursing education is not a priority for Romanian politicians as the government's key interest are to retain the Romanian nursing workforce within Romania, and therefore to adapt to EU legislation so that only a small segment can apply for mutual recognition. The Romanian government interpreted harmonisation with the European Directive on MRPQ mainly as a means of keeping everything as it was and developing new institutional structures for the recognition process within the Ministry of Education, the Ministry of Health and the Ministry of Labour, all with diverging tasks within credentialing. Several new departments were created for credentialing but civil servants also created new posts to safeguard their own future employment following EU accession.

Related to the different nursing bodies, the conflict of interest between the OAMMR and the Ministry of Health remains unresolved. Also, greater transparency is needed to build trust between policy stakeholders. The lines of accountability and responsibility between the OAMMR and the Ministry of Health were not addressed before or after EU accession. Links between the leadership of professional and trade union organisations, the OAMMR and the CNO needs to be strengthened to enable effective contribution to the EU-wide policy process.

Finally, the nursing regulator (OAMMR) developed on the basis of the TAIEX experts' 2002 recommendation has impacted most on the development of nursing legislation during and after

EU accession. Nurses trained under the former Communist regime's educational system, the sanitary system, have not been upgraded and only nurses who entered nursing schools after 2007 (with new curricula) comply with the Directive 2005/36/EC. The regulator's motivation relates mainly to keeping nurses in Romania, a position in line with that of the government and of the Nursing Union. Although leaders of the RNA advocated upgrading of all Romanian nurses, they became isolated as their views did not suit Sanitas or the CNO in the Ministry of Health who also occupies a leadership post in the OAMMR. Nevertheless, the European Commission has been alerted to the very different views regarding compliance with the Directive, and the Romanian Parliament has become more engaged (although post enlargement little can be done to readdress these topics with the European Commission). There is a theoretical possibility of a legal challenge in the European Court of Justice but non-state stakeholders are insufficiently prepared to take this up.

6.4 Conclusions

As related to the study objectives, the findings emerged in three sets of data: (i) the context; (ii) the process; and (iii) the outcomes.

In relation to the policy context, living through a totalitarian regime made nursing leaders more prepared to enter the EU accession process. The Romanian findings identified seven specific contextual conditions impacting not only on the way that nursing leaders in Romania engaged in the *Acquis* but also on the legislative and professional outcomes. The behaviours and skills developed and acquired during the pre-democratic regime were characterised by four distinct approaches: (i) a series of survival tactics; (ii) adopting a double identity; (iii) drawing on existing networks; and (iv) extending these by engaging with civil society (Zwi, 2001). Together these behaviours strengthened nursing leaders' capacity to engage positively in the EU accession process prior to entering the EU policy compliance negotiations.

Three major contextual factors counteracted these positive forces: (i) the legacy of Soviet Semashko working conditions; (ii) medical domination; and (iii) political instability within the country. These were identified as the main barriers to successful engagement in the EU accession process. Together these seven factors help to explain the policy outcomes achieved.

Those findings referring to the process indicate that the mechanisms enabling nursing leaders to engage in the EU accession policy process were limited to only two available Commission instruments – the comprehensive monitoring reports and the TAIEX peer review reports – since no use was made of capacity-building seminars. The TAIEX reports were treated as a negotiation tool between the government and the Commission without any engagement of non-state nursing stakeholders. Although these mechanisms can have political impact, the Romanian government reluctance to admit that Romania lags behind and being too proud to say Romania is not complying with EU law – impacted negatively on the process to build the capacity to design policies.

Concerning the achieved outcomes, findings indicate that nursing education was not a priority for Romanian politicians as the government's key aim was to retain the Romanian nursing workforce within Romania, adapting to EU legislation so as to enable only a small segment to apply for mutual recognition. The Romanian government mainly interpreted harmonisation with the European Directive on MRPQ to mean keeping everything as it was and developing new institutional structures for the recognition process within the Ministry of Education, the Ministry of Health and the Ministry of Labour, all with diverging tasks within credentialing.

Finally, the nursing regulator (OAMMR) developed on the basis of the TAIEX experts' 2002 recommendation has impacted most on the development of different nursing legislation during and after EU accession. Nurses trained under the former Communist regime’s educational system, the sanitary system, have not been upgraded and only nurses who entered nursing schools after 2007 (with new curricula) comply with the European Directive 2005/36/EC. The regulator's motivation relates mainly to keeping nurses in Romania, a position in line with that of the government and of the Nursing Union. Although leaders of the RNA advocated upgrading of all Romanian nurses, they became isolated as their views did not suit Sanitas or the CNO in the Ministry of Health who occupies a leadership post in the OAMMR. Nevertheless, the European Commission has been alerted to the very different views regarding compliance with the Directive, and the Romanian Parliament has become more engaged (although post enlargement little can be done to readdress these topics with the European Commission). There is a theoretical possibility of a legal challenge in the European Court of Justice but non-state stakeholders are insufficiently prepared to take this up.

Chapter 7 The Croatian case study findings

In this chapter the research findings on the context, process and outcomes of Croatia's accession to the EU are critically examined in relation to compliance with the European Directive on the Mutual Recognition of Professional Qualifications (Directive 2005/36/EC). The findings are based on analysis of a series of interviews with 15 participants before Croatia's entry to the EU (in 2013) alongside three key sources of evidence – (i) the TAIEX peer review reports informing the Commission; (ii) comprehensive monitoring reports as endorsed by the European Council and the European Parliament; and (iii) the TAIEX capacity building reports. These demonstrated that progress is dependent upon consensus between the stakeholders engaged in the compliance process. The aim of the chapter is to present the evidence that the EU accession process provided a policy window for the Croatian nursing leadership to advance a professional agenda in Croatia.

The case study findings are framed according to the research objectives, starting with analysis of the policy context which helped and hindered nurse leaders to engage with the EU accession process. Data reveal that four regime-specific contextual conditions helped the Croatian nursing leadership entering the EU accession policy process – (i) self-identity; (ii) nurses' societal status; (iii) collective values; and (iv) the Balkan War. Two indicators were identified from the accounts as the main barriers to the engagement of the nursing leadership with the EU compliance process for Directive 2005/36/EC – (i) the medical public health model; and (ii) occupied civil society.

Furthermore, critical analysis of the mechanisms that the nursing leadership employed to engage in the EU accession process reveals that the Croatian Nurses Association (CNA) took the opportunity to influence policy outcomes afforded by the negative appraisals in the Commission's comprehensive monitoring reports and the TAIEX peer review report. It can therefore be argued that the Commission’s mechanism available to increase the policy capacity of nongovernmental stakeholders are a valuable tool for influencing the process and outcomes. The Croatian Nurses Association (CNA) applied for the EU-funded TAIEX capacity-building seminars that brought together members of the CNA, the nursing union and the nursing regulator with policy-makers from the Ministry of Health. Nurse leaders from candidate countries (including the Former Yugoslav Republic of Macedonia and Montenegro) and from potential EU candidates (e.g. Bosnia and Herzegovina, Serbia and Kosovo) also attended to share knowledge and best practices.

The policy agenda of nursing leaders and the extent to which policy goals have been achieved are critically examined in the proceeding analysis. This is based on the stakeholder mapping of views, interests and influence on the design of the Croatian Nursing Act in compliance with Directive 2005/36/EC. The findings reveal that nurse leaders employed their influence and advocacy capacity to advance nursing on the political agenda and communicate key messages to the public on what would be at stake if compliance was not achieved. However, the analysis demonstrates that the legislative outcome negotiated between the Croatian Ministry of Health and the European Commission does not include the entire Croatian nursing workforce. As such it can be argued that the Croatian nurse leaders did not seize EU accession as an opportunity to advance nursing as a profession in Croatia. During the period 2007–2011, the nursing leadership faced the difficult challenge of influencing its own community in order to advance the nursing agenda. Nurse leaders' views and experiences with the EU accession process are therefore considered positive.

The chapter concludes with a summary of the Croatian case study findings to enable comparison with the Romanian case study findings and to benchmark these findings with the existing policy literature.

7.1 Policy context

The findings indicate that the policy context determined the way that the nursing leadership entered the EU accession process. Analysis of the Croatian accounts identified six regime-specific contextual factors which impacted on the way the nursing leadership influenced policy-makers to reach compliance with Directive 2005/36/EC.

7.1.1 Self-identity

Participants perceived the Communist regime period between 1970 and 1980 to be "softer compared to the Communist regime in the Czech Republic, Romania and Slovakia" (C17 Nurse Leader).

Participants described the Communist period in the former Yugoslavia using terms such as "the golden years" (C1 Nurse Leader); "not the country behind the Iron Curtain" (C2 Politician); "open to the West" (C9 Physician/Policy-maker); "being a leading country when it comes to public

health" (C6 Politician/Policy-maker); and "flexible socialism" (C15 Politician; C18 Nurse Leader); with "opportunities to travel abroad and having the freedom to make own choices" (C19 Politician). The Communist regime in Croatia was experienced as milder than Ceausescu's totalitarian regime and more open to the West, as nurse leaders were able to link up with the Rockefeller Foundation in the United States of America and visit western European colleagues through WHO contacts (C5 Nurse Leader). All participants indicated that some degree of free market enterprise (market socialism) was allowed under Titoist Communism, and intellectual freedom was tolerated as long as the dogmas of Brotherhood and Unity were not criticised publicly (C16 Policy-maker; C19 Politician).

> "There was a human element in the repressions. This was also the case in judicial environments as judges sympathised with dissident and Western values. But you could not criticise Marshal Tito and the dogmas of Brotherhood and Unity, otherwise you ended up with 20–25 years in the Stara Gradachca or Goli Otok prison."(C22 Politician)

The nurse leaders and politicians interviewed also explained their participation in the Croatian Spring Movement that began in the 1970s and emphasised the Croatian people's desire for their "own identity" (C5 Nurse Leader; C9 Physician/Policy-maker).

> "In 1970 I worked on the Croatian Constitution and fought for Yugoslav republics to become states. When Slobodan Milošević came into power in Serbia, I – together with Franjo Tudjman and one part of left-oriented politicians – realised the time had come to create an independent state. We all formed the Croatian left-oriented group of politicians, the Social Democrats." (C19Politician)

Participants agreed that Tito's main objective was to strengthen his dogmas of Brotherhood and Unity and his own position of power but the nursing leadership argued that it was not the right time for Croatian independence within Yugoslavia. Tito's political concept prescribed that all Yugoslav ethnic groups (Serbs, Croats, Muslims by nationality, Macedonians, Slovenes, Montenegrins, Albanians and others) should be recognised as equal national groups and coexist peacefully in the federation. Tito's Communist Party had support in both ethnic Croat and Serb areas but the findings from the current study reveal that Belgrade was the main centre for policy decisions (C14 Nurse Leader; C5 Nurse Leader; C3 Nurse Leader; C1 Nurse Leader). Hence,

participants reported that it was impossible for the Croatian nursing leaders to change anything in the profession or the nursing care process, as they did not have a voice in the Belgrade Healthcare Workers Association:

> “I tried to do something about the professional level of nurses but I did not get support from Belgrade. The Belgrade Health Care Workers Association did not want to put in place a law for nursing.” (C5 Nurse Leader)

Participants describe a less idealistic side to Brotherhood and Unity in that the Communist regime refused to negotiate or accept the demands of the popular voices of any nationality who complained about the people's status or conditions. As evidenced by many participants, the usual response to such demands was arrest or execution (C19 Politician; C3 Nurse Leader; C9 Physician/Policy-maker).

> “When the Communist regime under Marshal Tito ended, I became the security advisor of Tudjman working on aiming to prevent conflict in the former Yugoslavia. The Communist regime had an institution that was called Internal Enemy: everybody advocating democracy, multi-party systems and independence of civil society, was an internal enemy. In both the Communist Party and the secret police, there were special units devoted to analysing the counter-revolutionary forces in society.” (C16 Policy-maker)

Although most interviewees considered the regime to have been softer and more open to the West, the Croatian accounts make reference to the development of a "double identity" in order to operate in a system characterised by fear and control (C5 Nurse Leader; C13 Physician; C9 Physician/Policy-maker): "Like Ceausescu had Securitate, we have here the secret police called OZNA" (C9 Physician/Policy-maker).

Participants explained that one part of their life was within their family – their private life. In this, people retained their freedom to live according to their own values and what they thought was good or bad. But these values ended at their doorstep.

Most participants perceived public life to be problematic since everybody had to be obedient. People had to listen to the power at the top, which did not allow space for creativity. The

ethnographic accounts report the creation of a submissive mentality in which people were used to living alike and listening alike but operating differently (Baillie, 1995).

Prior to entering the EU accession process, participants perceived that the double identity experience provided strength for the nursing leadership to influence the policy process. As one participant said, “I think the Communist regime made us strong. The willingness to overcome your own limits, your own values strengthened me” (C7 Policy-maker).

Nevertheless, the culture of threat and intimidation transformed into a societal culture that remained in place during EU accession negotiations. For example, the nursing leader advocating for nursing education to be upgraded received several threats warning her to stop (C5 Nurse Leader). Unknown forces opposing the upgrading of nursing education wrote to the Bishop of the Catholic Church and created an atmosphere of fear and threat such that the nurse leaders advocating for professional change now intend to give up their political advocacy work (C21 Physician/politician).

Based on these findings it is argued that self-identity had a significant impact on the nursing leadership's engagement with EU accession: "Before 1990, people were left with the sense of false security. The EU could offer a new kind of security" (C2 Politician).

7.1.2 Nurses’ societal status

With respect to the EU accession process, the capacity of the nursing leadership, policy-makers and politicians needs to be interpreted within the context of the construction of the different segments of society as developed during Communism. Different participants (C3 Nurse Leader; C5 Nurse Leader; C9 Physician/Policy-maker) described how policy-making during the Tito regime was in the hands of:

> "a small group of people constituting the centre of the Communist regime, a narrow segment of opposition belonging to the intellectual underground, and the huge silent majority of the population accepting the dogmas of the Communist regime as part of their daily life" (C9 Physician/Policy-maker).

According to the participants, policy-making within the Communist regime took place in "a very simplified model" in which a very narrow group (generally 10–15) of Communist Party members took the principal decisions simultaneously at national, regional and local level: "The important

decisions were taken above our head. The political decisions were centralised. We do not have any impact" (C9 Physician/Policy-maker).

Nevertheless, individuals opposing these decisions used the media to influence the policy-making decisions of this small group of people at the centre of the Communist regime.

> “I was leading a cultural publication START. The leaders of the Communist regime underestimated the influence of this magazine which reached between 150 000 and 250 000 citizens. More importantly, there was a special communication between the authors and the readers. The readers were accustomed to reading between the lines and the authors used a metaphorical language to pass on the message. Certain columns had a huge impact on the development of Communist policies.” (C16 Policy-maker)

Next to the strengths developed to communicate through the media, most participants confirm that the nursing profession’s status in Croatia was determined by a traditional patriarchal society in which women are undervalued. This is reflected in the imbalances in the power relationship between physicians and nurses in the health-care system – nurses are treated as second class citizens. Interviewees argued that:

> "As physicians focus on diagnoses and treatment power, when taking up a political role, physicians have difficulties in making a distinction between the decision-making rules in the medical profession and the decision-making rules in the political environment." (C9 Physician/Policy-maker)

Participants consider that, if leadership is to be effective, there needs to be a distinction between professional and political decision-making (C6 Politician/Policy-maker).

In contrast, some interviewees (mainly politicians and policy-makers) perceive nurses and their leaders to be "dreaming" (C19 Politician) because of their altruistic motivation. Therefore, when engaging in the politics of policy-making the nursing leadership "need to get up and join hands and first do something for their own profession as a common priority" (C9 Physician/Policy-maker). One participant added that when the nursing leadership achieved reaching being an autonomous profession, the nurse leaders need to be proud about the decisions taken" (C20 Media).

Prior to entering the EU accession policy process, participants considered it crucial that as many people as possible knew as much as possible about the nursing profession. For example, who nurses are, what nurses do and what added value nurses and nursing bring to the public and society? Some participants commented that nursing leaders' advocacy (for patients' rights, human rights, quality and accessibility of care and safety and security within the health-care system) is perceived as a strength and advantage when influencing policy (C12 Civil Society Advocate; C22 Politician; C4 Political Scientist): "If governments do not have the nurses with them, they will face major difficulties in implementing what they envisage they need to do" (C16 Policy-maker).

In line with this perception, nurses and their leaders are perceived by politicians and policy-makers (C22 Politician; C15 Politician; C10 Psychologist) as a "healthy voting constituency without disturbed and biased views, being able to create its own stand on what is good for citizens, patients and society" (C22 Politician)

Nurses have high credibility in society, and "Credibility is a very important characteristic of a leader. Every leader has to have credibility" (C5 Nurse Leader). Several accounts indicate that nurses and their leaders should become politicians and thereby assume more prominent positions within the policy processes underpinning the health-care systems: "As nurses understand power, the nursing leadership must have a real vision of what they want to achieve in politics" (C22 Politician).

7.1.3 Collective values

Participants indicated that, although policy decisions were taken by a few people, the policy agenda needed to be based on the "collective values" inherent in the Communist regime (C15 Politician; C11 Nurse Leader; C7 Policy-maker; C9 Physician/Policy-maker; C1 Nurse Leader). One participant argued that:

> "There are many good elements in the collective culture: in relation to public health, we had a promising model because it was based on equity among individuals, local and regional solidarity and overall social security" (C3 Nurse Leader).

One interviewee said that: "the Croatian Communist regime found life for society, being part of society, very important" (C9 Physician/Policy-maker). Another said: "What I got from the Communist regime is the feeling that you have to be part of society" (C9 Physician/Policy-maker).

The collective values identified in the accounts relate to "having a sense of justice", "thinking independently", "engaging with society", "serving the people around you", "doing something valid in life", "building trust" and "being constructive and honest" (C15 Politician; C11 Nurse Leader; C5 Nurse Leader; C2 Politician). Participants perceive these values to be central to the enthusiasm needed to engage in the Croatian health-care system and the development of the nursing profession when entering the EU. They argue further that the collective value system must underpin the nursing leadership if it is to achieve successful policy outcomes: "even in the time of communism, people who stood up for principles and values were respected" (C14 Nurse Leader).

Within this policy context, participants also argued that the medical profession is more interested in obtaining appointed positions than standing up for collective values.

> “When I started working with Tudjman, I worked with economists, philosophers and sociologists and not one would accept an offer to work with the government. It was risky and against their leftist value system. On the contrary, when I invited physicians to work with the government, they accepted immediately. They even recommended other physicians. Physicians like to be nominated by politicians." (C19 Politician)

The ability to hold on to collective values can inspire people to drive change in very difficult policy conditions. The accounts make it clear that "parents and grandparents are crucial in developing and holding onto the collective values, next to leadership role models" (C9 Physician/Policy-maker). Other participants illustrate that "parents give a sense of justice, security and democracy" (C15 Politician). One nurse interviewed explained:

> “My mother and grandmother, who played a significant role in my development, talked about how difficult it was after World War II. My grandmother, who lost two children during World War II, always said to me: 'your knowledge and your values are the most important to develop and nobody can take them away from you. Nobody can break you down. You need to develop yourself in order to serve the people around you'.” (C17 Nurse Leader)

Furthermore, participants named nurses such as Luiza Wagner, Gordana Pashcara and Milena Delac; former Minister for Foreign Affairs, Olinda Garder; Professor Andrija Štampar and Professor Valcovich as leadership role models.

> “I was fascinated by women who were in high political positions, for instance Savka Dabčević Kučar. Then I remember Milka Planinc, Jovanka Broz, Tito’s wife. Only women.” (C14 Nurse Leader)

Next to family members, colleagues and prominent politicians, participants mentioned the Catholic Church's importance during the Communist regime as it provided a framework for holding on to collective values. Participants commenting on the creation of human values refer to the traditional religious communities, the Catholic Church and the Orthodox community rather than Communism.

7.1.4 Balkan War

Participants consider the ethnic dimension in which the nursing leadership grew to maturity in Croatia to be an important contextual factor for engaging differently in the EU accession process. They explain the nationalistic desire for independence that developed during the Croatian Spring (1968–1971), although it was not until 1991 that Tudjman and his right-wing Croatian Democratic Union (HDZ) seized the political opportunity to declare independence for Croatia.

> "In 1990, the first political parties were formed. I received an invitation from Tudjman’s Croatian Democratic Union – HDZ – aiming at constructing the nation and keeping together the sense of national identity." (C15 Politician)

Serbs, Croats, Bosnians and Montenegrins had a common enemy under the Soviet Union’s ideology and so there was more solidarity between ethnic groups. When this enemy disappeared, the traits of nationalism and extremism appeared on the political scene.

> "The government consisted of three entities, the Serbs, Muslims and Croats. Everything looked promising but in 1991 we started to feel tension. Suddenly all Muslims and Croats were “Ustaše”, the name used for people who supported Hitler during World War II and promoted Croatian nationalism, led by Ante Pavelic, in 1940–1941." (C19 Politician)

It was only in 1991 that Slobodan Milošević, the son of a Serbian Orthodox priest and a hard-line Communist school teacher, sent tanks to the Slovenian borders, triggering a brief war that ended in Slovenia's secession and moving the whole Balkan region into a bloody ethnic war:

"Persecution of Croats and Muslims started on 29 April 1992. The Serbs took over the power and government where the Muslims had a majority" (C22 Politician).

In their accounts, participants described that the Balkan War created chaos in policy-making as diplomacy and politics have been always governed by Serbs. They left their policy-making posts when hostilities started. Once persecuted by Yugoslavia and the Serbs, many opposition members returned from abroad as they now saw opportunities to take up political leadership (C22 Politician; C15 Politician). Some participants reported that the Cabinet of the War Government comprised 26 former communists, highly educated and expert in different fields such as economics, law and politics. Even in the army, Tito's generals and admirals (all Croats) moved to the new leadership's side when the war started. This is reflected in the account of a political scientist:

> "The first army general, Imra Agotić, director of KOS, the former intelligence service and General Tus, commander of the air force of Yugoslavia, took up leadership within the War Government. General Stipetić and General Špegelj joined as well. The same happened within the police forces, the OZNA, the Yugoslav intelligence services, and many Croat officials joined the War Government. Concerning the economy, the main managers were all former company directors from the Communist regime". (C15 Politician)

Participants further explained that, in relation to the intellectual community, the Balkan War did not stop innovation and reflection. Instead, the situation became an opportunity for scientists to move on, to set the political agenda and to design and implement new strategies: "I was in Zagreb, went to shelters, held courses and symposiums in my faculty, and had discussions about democracy. Nothing stopped" (C3 Nurse Leader).

Within the nursing profession, the CNA became independent of the Belgrade Healthcare Workers Association. Therefore, the narrative that the Croatian nursing profession could not develop during the war is not confirmed by the data. Instead, the war provided an opportunity for Croatian nursing leaders and policy-makers to start proactive development of the first Croatian Nursing Act (1994). On the basis of this, the Croatian nursing leadership was prepared to enter EU negotiations although Croatia submitted only a formal application for EU membership in February 2003.

> “In Slovenia and Croatia, we tried to do something about the professional level of nurses but we didn’t get support from Belgrade. The Belgrade Health Care Workers Association didn’t like to put in place a law for nursing. But in 1994 we managed to implement a law and article 21 which says nurses are independent persons and can become an independent worker. This was new.” (C5 Nurse Leader)

Some participants refer to "the coping strategies needed to deal with the consequences of war. Almost everyone who lived through the war has post-traumatic stress disorder" (C12 Civil Society Advocate). Some interviewees stress that it will take more than one generation to cope with the consequences.

> “It was a difficult and painful time and it is still fresh and deep in the minds of the people and although nobody talks about it, there is a lot of anger circulating around. The problem is: nobody was helped to digest it." (C13 Physician)

The war's impact on the way that the nursing leadership influences the design of policies, especially when engaging with the EU accession policy process, cannot be ignored. Nurse leaders interviewed referred again to the collective values of nursing required to deal with refugees, especially children without parents. A head of school said: "the nursing schools were filled up with refugees and focused on making sure these children entering nursing did something valid in life" (C17 Nurse Leader). Other participants note that: "in all refugee camps, networks of friends were constructed to support each other ... the teenagers had their own special network of support and friendship from which they branched out" (C22 Politician). Nurse leaders and policy-makers indicate that these networks are important channels for the provision of moral support.

Finally, several interviewees described that: "due to the war the 'camaraderie' between physicians and nurses enabled them to do more than they would otherwise be able to do" (C13 Physician). Several interviewees remarked that the context of war, of going through extreme conditions, created "a band" which, according to one physician interviewed, continues.

> "That band implies that as long as this generation of nurses and physicians meet, there will be a special connection between both professions, benefiting the development of the health-care system." (C13 Physician)

As one interviewee said: "When nurses and physicians agree, great things can happen" (C14 Nurse Leader). This suggests that the Croatian nurse–physician relationship developed by living through the war can impact positively on policy outcomes and is an important indicator for analysing EU accession policy outcomes: "Since the war, one could see the highest level of solidarity between nurses and physicians. We were really a tightened team" (C17 Nurse Leader).

Next to these four indicators facilitating the nursing leadership's engagement in the EU accession policy process, the inductive analysis identified two factors hindering the nursing leadership from influencing the policy process and outcomes – (i) the public health medical model; and (ii) the occupied civil society.

7.1.5 Public health medical model

When considering the obstacles to engagement in the EU accession policy process, participants indicate that (as was the case in Romania) medical dominance is perceived as an important barrier.

Nursing education in Croatia has a long history in comparison with other eastern European countries. Professor Andrija Štampar played a significant role, holding a high political position in the *Liga Naroda* (League of Nations) and becoming one of the founders of the World Health Organization in 1948. He gave nursing education a prominent place on the public health agenda, providing international links with the Rockefeller Institute in the United States and organising a postgraduate training programme for nurses in public health.

> “Andrija Štampar was a great champion for nurses in the 1950s. He was visionary and organised nursing education within the public health university, together with the other health-care professions. Nursing was not within the medical faculty, it was, together with the physicians, in the public health institute at that time. Nursing education had a cycle of three years but this system only lasted till 1969.” (C3 Nurse Leader)

Andrija Štampar was entrusted with the task of taking over as head of the former Yugoslav Health Service in Belgrade. He surrounded himself with a group of young people with an interest in social medicine but his initiatives aroused bitter controversy within the medical profession who saw their traditional medical model being threatened by a public health model. Štampar struggled to

introduce the subject of social medicine into the regular curriculum of medical schools (C3 Nurse Leader; C9 Physician/Policy-maker). As confirmed by one participant:

> "the main opposition to Štampar's developments came from the Croatian Medical Chamber and the Medical Association, which perceived his developments as being opposed to their professional and economic interests" (C3 Nurse Leader).

The medical opposition pushed for the introduction of legislation on secondary schools which resulted in the closure of the Nursing School for Higher Studies. Participants (C1 Nurse Leader; C3 Nurse Leader; C5 Nurse Leader) describe the period between the end of the 1950s and the beginning of the 1970s as: "a dark period with the reorientation towards secondary schools for nursing education" (C5 Nurse Leader). Many secondary schools for nurses opened across the country, including those in Osijek, Rijeka, Karlovac, Varaždin, Pula, Zagreb, Dubrovnik and Split.

According to most nurse leaders, this period in the history of Croatian nursing education created the main challenges facing Croatia as it entered the EU accession process. Participants (C6 Politician/Policy-maker; C11Nurse Leader; C5 Nurse Leader) indicate that "these changes had devastating consequences for nursing education due to its superficial approach and predominantly medically and technically orientated curriculum" (C6 Politician/Policy-maker). A nurse leader described the effect: "in hospitals and institutions for primary health care, nurses with higher degrees were replaced by nurses with secondary school certificates, this being an important political signal from the Tito regime" (C5 Nurse Leader).

The status of nurses in Croatia was downgraded and nursing became medically dependent and medically oriented. It is within this policy context that the nursing leadership entered the EU accession process.

7.1.6 Occupied civil society

Participants stressed that when Croatia moved from dictatorship to a liberal democracy, the political players stayed the same and continued to operate in a fashion similar to their actions during the Communist regime. Some participants (C4 Political Scientist; C13 Physician; C16 Policy-maker) made reference to "although symbols, constituencies and legislation changed, the movers and shakers survived the Balkan War and the collapse of an ideology and stayed in positions of power" (C4 Political Scientist).

This indicates that the move towards liberal democracy ensured some continuity of political leadership and that crucial positions of political power were not given up. The degree of overlap between both regimes is significant as, in contrast to the Romanian case, most participants make reference to civil society being occupied: “Marxist politicians from 20 years ago are born to be in power” (C4 Political Scientist).

Most Communist players are now in different political parties, not just the Social Democratic Party of Croatia (SDSH). Some former communist politicians present themselves now as apolitical and integrated into civil society; some have even become human rights activists. Several accounts indicate that past Communist Party leaders – powerful Croatian politicians – became "fighters for human rights", thereby demonstrating a capacity to take on a new identity and adapt to a new policy context and political environment.

> "I kept on trusting the Prime Minister Ivo Sanader, a very good friend who in 2005 put me in the position of President of the Governmental Office when he was Deputy Minister for Foreign Affairs." (C22 Politician)

Another account (C19 Politician) describes an organisation called the Forum for Croatian Unity (C19 Politician), a self-selected pressure group for tolerance led by scientists, professors, former government ministers and presidents, members of the former Croatian War Government, members of the biggest Croatian football club and prominent economic experts. With over 300 members, this ‘civil society association uses non-political means to influence politicians in connection with national interests. This concentration of people wields more power than any government or political party. "During the war the representatives of this organisation received lots of money. If you wanted to launder money, that was the place to be" (C22 Politician). These former Communist political leaders are well-educated, infiltrate into civil society and know how to handle the media to advance their political agenda.

7.1.7 Summary

The analysis of the ethnographic accounts indicates that, although all participants perceived the Communist ideology to be controlling and oppressive, four indicators (self-identity; societal status; collective values; Balkan War) helped the Croatian nursing leadership to develop their influence on the EU accession policy process. At the same time, two other indicators (public health medical

model; occupied civil society) made it difficult for the nursing leadership to push for legislative and professional change during the process.

The Croatian case study findings provide evidence on how the Communist regime created a committed and value-driven nursing leadership within a largely patriarchal society. As in Romania, the nursing leadership had to adopt a submissive double identity in order to survive. Tito's regime was based on fear and control in which market socialism was embedded in the dogmas of Brotherhood and Unity, which were not to be publicly criticised. Belgrade was the centre for policy decisions and Croatian nurse leaders were prevented from making any changes to upgrade nursing education or their profession as the medical professions retained their tight hold on traditional medical education. It was only when Serbs left their policy positions during the Balkan War that the nursing leadership could start to develop a nursing law. Surprisingly, the war did not stop innovation or reflection and even provided opportunities for proactive design of nursing legislation.

Unfortunately, those who had been Communist Party leaders rebranded themselves as 'fighters for human rights.' In contrast to Romania, these powerful Croatian politicians occupied civil society – described by participants as a concentration of people with more power than any government or political party. The nursing leadership therefore distanced itself from civil society when entering EU accession.

The nursing Croatian leadership grew eager to enter EU accession and many participants began to perceive them as a healthy voting constituency. Therefore, before and during the EU accession policy process, the nursing leadership remained apart from occupied civil society and communicated continuously and directly with the public to explain the value of nurses and nursing in Croatia and the EU. It is argued that the collective values derived from their role models helped to strengthen the nursing leadership entering the EU. It is therefore not surprising that – according to most nurse leaders interviewed – the main drivers for nurses' continuing commitment to the nursing profession are safeguarding the values of solidarity; democracy and human rights; developing public health; and respect. All values which gained prominence during the Balkan War. Although ethnic groups were disrupted, nurse leaders from these different ethnic groups continued to communicate informally with each other. This allowed them to build policy capacity jointly prior to entering the EU.

Before evaluating the legislative and professional outcomes, it is important to explore the processes and mechanisms through which nurse leaders engaged specifically with the *Acquis* (research objective 2).

7.2 Agenda-setting mechanisms for engagement in the EU accession process

The Croatian nurse leadership engaged with the *Acquis* by means of three main processes and mechanisms: (i) the Commission's comprehensive monitoring reports based on (ii) the TAIEX peer review reports and (iii) the TAIEX capacity building seminars. In contrast to Romania, the Croatian nursing leadership used the latter to their full potential at different points during the accession period. The ultimate aim was to bring together competing and conflicting nursing stakeholders and build consensus in views and opinions with the policy-makers (mainly physicians and lawyers) negotiating the *Acquis*. Nevertheless, the Croatian government was reluctant to take up the recommendations formulated by the nursing leadership in the TAIEX peer reviews and capacity building seminars.

In addition to the opportunity to influence policy development through these three identified Commission's mechanisms, participants perceived the Croatian EU accession process to be a way of bringing peace to the Balkan region. Croatia became the first test case for other Balkan countries seeking to join the EU, as the June 2003 Thessaloniki European Council (EC2003/76279) confirmed the prospect of accession for all western Balkan countries (Albania, Bosnia and Herzegovina, Croatia, former Yugoslav Republic of Macedonia and Serbia). Nurse leaders from these prospective EU MS joined the Croatian capacity building sessions to learn about the EU and Directive 2005/36/EC.

7.2.1 Commission's comprehensive monitoring system

Croatia formally applied for EU membership in February 2003. Following the favourable Commission Opinion in April 2004, Croatia was granted official candidate country status at the European Council meeting of 17 June 2004. Scheduled for March 2005, the EU postponed the start of negotiations to await Croatia's full cooperation with the International Criminal Tribunal for

the former Yugoslavia. Following General Ante Gotovina's extradition to The Hague on 7 December 2005, Croatia commenced the long-awaited accession negotiations in February 2006.

Croatia's accession to the EU therefore differs from the Romanian case as compliance with the political prerequisites for EU accession – stability of national institutions guaranteeing democracy, the rule of law, human rights and freedom of expression – depended on the Croatian government's full cooperation with the United Nations Tribunal.

It is important to acknowledge that, in the 1990s, when other post-communist countries in Central and Eastern Europe were strengthening their democracies and paving the way towards EU integration, only Croatia's EU aspirations were halted by the Balkan War.

Two former constituent republics of the Socialist Federal Republic of Yugoslavia, Croatia and Slovenia, with common Yugoslav state socialist heritage, divergent war experiences, and different post-independence political regimes made both countries paths to EU accession diverged. While in post-independence Croatia the primary factors responsible for paths divergence were a combination of the war and the Tutjman government's economic mismanagement, Slovenia moved successfully towards a European market economy due to their efforts to prevent sharp loss of GDP and sharp rise in inflation and unemployment.

For Croatia it was not until 2000 that a genuine parliamentary democracy became eligible for EU candidate status with notably full cooperation with the United Nations' war crimes court. Several interviewees explained that:

> "Croatia had the problem of being a part of the federation, former Yugoslavia. As diplomacy and politics were not led by Croatians, when Croatia became independent in 1990s there were no Croatian diplomats as in the past these positions were held by Serbs." (C1 Nurse Leader)

Different participants voiced their support for Croatian independence but equally stated that:

> "Croatia should be a leader of the Balkan region in order for other Balkan countries to become members of the EU. It is in Croatia's interest that Former Yugoslav Republic of Macedonia, Bosnia and Herzegovina and Serbia become part of the EU since it is crucial for future development and security in this area." (C2 Politician)

As advocated by a nurse leader in the Ministry: "Croatia must become a member of the EU because it is the only way to live together, to live in peace" (C3 Nurse Leader).

Based on these aspirations for EU membership and for keeping peace in the Balkan region, compliance negotiations for Chapter 3 of the *Acquis* started in 2006 with the provisional closure date of December 2010. The deadline to join the EU is July 2013.

The annual Commission monitoring reports are an important tool for enabling European political leaders in the Council and European Parliament to evaluate Croatia's progress in accession to the EU. They are equally helpful for enabling the Croatian nursing leadership to hold the Croatian government accountable for the lack of progress in fulfilling the economic and political prerequisites for EU accession (EC/2005; EC/2006; EC/2007; EC/2008; EC/2009; EC/2010). Notably, nurse leaders in other prospective EU MS have not used this latter opportunity to influence nursing's political leaders to inform their governments about any lack of compliance.

In relation to the freedom of services and the freedom of establishment to provide services – as set out in Chapter 3 of the *Acquis* – the Commission's and Croatian government's negotiations on Directive 2005/36/EC were opened on 26 June 2007 and closed on 21 December 2009. Given the diversity of views on compliance and the numerous Commission progress reports highlighting the need for more efforts to achieve compliance with the Directive, from an empirical perspective it is impossible to explain the closure of Chapter 3 in such a short period – the first positive Commission report on compliance with the Directive 2005/36/EC did not come until 2010.

Over a five-year period of Commission reporting, reference is made to the lack of harmonization of the rules concerning regulated professions to ensure the mutual recognition of qualifications and diplomas between MS. The 2005 report refers to the Croatian government setting up a centre for academic mobility and recognition of higher education qualifications within the Agency for Science and Higher Education. This appears to cover mainly academic recognition, with limited impact on the recognition of professional qualifications. In 2006 and 2007, the Commission monitoring reports to the Council and European Parliament indicate that no progress could be observed regarding the mutual recognition of professional qualifications. The reports stipulates that the Croatian legislation does not distinguish between the recognition of academic and professional qualifications, since Directive 2005/36/EC concerns only the professional qualifications of the health professions covered by the sectoral regime.

The 2008 Commission report highlights that the minimum training requirements for all medical professionals – doctors, dentists, midwives, nurses, pharmacists – are still not in line with the *Acquis*. Furthermore, neither nurse training at secondary level nor midwifery secondary-level education comply with the Directive, nor in-service training for fifth-year pharmacists also falls short of the requirements. The 2009 Commission monitoring report mentions some progress on the mutual recognition of professional qualifications. However, the minimum training requirements for medical professionals – doctors, dentists, midwives, nurses, pharmacists – are still not in line with the *Acquis*. The report identifies the need to strengthen administrative capacity concerning mutual recognition of qualifications as further efforts are needed in this area.

Nevertheless, Chapter 3 of the *Acquis* was provisionally closed in 2009, following the Croatian government's agreement (in principle) to install nursing education at university level. Hence, the 2010 Commission monitoring report makes the first mention of good progress on the nursing curricula. The report also notes that further action is required to bring the minimum training requirements for the remaining medical professions into alignment with the *Acquis* as the amendments to the Midwifery Act have not yet been adopted.

Based on this analysis, it can be argued that, as in Romania, compliance with Directive 2005/36/EC was not a major concern of the government. Therefore, the Commission's comprehensive monitoring reports seem to be ineffective in bringing the entire nursing workforce into compliance with Directive 2005/36/EC.

7.2.2 Commission's TAIEX peer review mechanism

As detailed in Chapter 5 on the Romanian case study findings, the TAIEX peer review reports are written up by nursing experts selected by the Commission. The first peer review visits for Croatian nursing took place at the High School Mlinarska; the University of Rijeka – Nursing Studies; the Clinical Hospital Centre Rijeka (emergency unit, intensive care unit, paediatric unit, surgical unit); the Medical Centre Primorsko-Goranska County; and the Home Care Unit Helena Smokrović. The evaluation was based on information provided by the Croatian authorities in response to the Commission's questionnaire sent out in June 2008 and additional documentation supplied by the Croatian authorities.

Analysis of the July 2008 TAIEX peer review report reveals that the TAIEX nursing experts from Hungary and Cyprus held different views to those of the Croatian government concerning compliance with Directive 2005/36/EC. These diverging views relate to the Directive's minimum requirements, including: (i) a minimum entry level of 10 years of general education; (ii) a full educational programme of 4600 hours and 3 years; (iii) an educational programme comprising one third theoretical training and one half clinical training on a full-time basis; and (iv) the nursing curriculum must include at least the programme as described in Directive Annex 5.2.1.

The content of the TAIEX report was critically analysed in relation to the policy goals achieved (see section 6.4.1.1), the two appointed nursing experts concluded their report by saying that "the legal or administrative provisions laying down the minimum training requirements to be respected by all training institutions were still missing in Croatia" (C3 Nurse Leader).

Between 2006 and 2010, the Ministry of Health negotiator, a physician, argued that the existing secondary nursing education in Croatia was already in compliance with Directive 2005/36/EC. One participant – a member of the negotiation team – recalled that she:

> "Was surprised to find out that the negotiations on the health professionals' mutual recognition was led by doctors and lawyers who do not know what nursing is about ... At Zagreb airport I met with two lead negotiators, and I asked what our strategy was in case we are asked some questions. During the conversation it became clear to me that Mr. X did not know that nurses were educated at secondary level and he even surprisingly asked me 'Since when has Croatia had these secondary schools for nursing education?' I answered 'Well, sir, since about 100 years ago!'" (C8 Nurse Leader/Policy-maker)

This evidence shows the low baseline of information among negotiators. Another participant adds that the negotiators from the Croatian government should understand that: "nurses are doing a lot of tasks which they shouldn’t do, as these mainly technical acts, e.g. surgical wound closure, are not legal" (C5 Nurse Leader). The participant familiar with regulation acknowledged that "It is important to upgrade the Croatian nurses by putting in place EU bridging courses so nurses can then operate in a legal way" (C3 Nurse Leader). Nevertheless, the nurse supporting the negotiation team with translations stated during interview that:

> "We know what Europe wants from us and it is the responsibility of the negotiation team to negotiate the terms and conditions enabling those nurses with a lot of years of experience who have been in the health-care system for a long time to be recognized by the EU as such." (C8 Nurse Leader/Policy-maker)

She continued saying that her main challenge was to inform politicians and policy-makers negotiating EU accession about what nursing in Croatia is about and how it looks like in other MS, what nurses do in practice and how this relates to a different skill mix outside Croatia and its impact on patient outcomes. She continued saying that:

> "In relation to the politics it is completely up to the politician in charge. If that person does not understand anything about the nursing profession, regulation or EU law, we cannot move on." (C8 Nurse Leader/Policy-maker)

A political scientist interviewed added that:

> "It is not smart to openly confront the current generation of politicians and policy-makers... Don't give destructive criticism but be constructive. Employ constructive criticism to change an educational system." (C4 Political Scientist)

Participants indicate that it is difficult to understand why physicians were negotiating on behalf of nursing. Consequently, most Croatian participants, the nursing regulator, the professional association and the nursing union, did not agree with the position that "there are no problems" (C17 Nurse Leader; C5 Nurse Leader).

As in Romania, complacency is an important barrier in the agenda-setting process to achieve compliance. One political scientist interviewed made reference to Thomas Kuhn's research and his book *The Structure of Scientific Revolutions,* arguing that there is:

> "Something conservative in the way the Croatian government introduces something completely unknown to Croatian education system as the government pretends Croatia has it already in place ... There is an unshaken continuity in the way the Croatian government organises the educational system in Croatia. They pretend to accept the *Acquis* but nothing changes." (C4 Political Scientist)

This view is confirmed by a nurse leader reporting that:

> "80% of the Croatian nurses finished only secondary nursing school while nursing as a profession needs to have a scientific level of education for future nurses and develop evidence-based clinical practice. Nevertheless, this is going to be difficult to achieve in Croatia since today nurses are not perceived in Croatia as a scientific profession." (C1 Nurse Leader)

Most participants' accounts provide sufficient evidence that the Croatian nursing curriculum does not meet the minimum training requirements set out in Directive 2005/36/EC. As one interviewee indicated:

> "The Health Minister wants to keep the secondary level of education for nurses. We still have in Croatia the socialist way of education which is the secondary-level nursing schools consisting of 4 years of studies but if we count nursing-related theory, we have only 1200 hours of nursing. The rest is all generic stuff. This is the problem current policy-makers are not willing to face." (C5 Nurse Leader)

It is striking that the Secretary of State, a physician, gained political backing for not upgrading nursing education with EU accession funds, despite knowing that "over 80% of the nurses are secondary-level nurses and do not meet the EU standard" (C10 Psychologist).

In 2012, the new government realised the lack of progress and asked for a new TAIEX peer review mission. The experts (nursing leaders from Spain and Ireland) concluded that the two levels of nursing education for general care nurses persist – vocational education and training leading to the qualification of nurse/medical technician; and higher education leading to a bachelor's degree in nursing. The programmes have very different outcomes and lead to a very different scope of practice for the nurses. The secondary school programme does not prepare students for decision-making regarding evaluation of overall health care (breaching Article 31 of the Directive) and clinical instruction for both levels of nursing education is not organised as outlined in Article 31.5.

Although the nursing leadership maintained conflicting views on how to address the weaknesses raised by the TAIEX peer reviews, the nursing leadership of the professional association

organised different TAIEX policy capacity building seminars – financed by the European Commission – in order to keep non-compliance on the political agenda.

7.2.3 TAIEX policy capacity building seminars

Negotiations on compliance with the Directive started between the Ministry of Health and the European Commission in June 2007. At that time, the diverging views on compliance held by the nursing stakeholders – mainly the nursing regulator and the professional nurses' organisation – became public.

It is useful to summarise these contrasting views. For example, the Croatian Nurses Chamber considers that all secondary schools for nurses should be changed or closed. The CNA opposes this because it would result in fewer nurses in the health system and fewer members of the nursing profession. At the start of the negotiations, only the curricula of the three-year vocational and specialist studies complied with Directive 2005/36/EC. This implies that only about 6% of Croatian nurses would meet the EU minimum requirements (Kalauz et al., 2008).

In addition, the Croatian Nurses Chamber asserts that all nurses should enter vocational nursing studies in order to gain a bachelor's degree and those nurses currently practising who trained at secondary-level nursing education should complete higher vocational nursing studies – the bachelor's degree or the vocational master's. In addition, current educational nursing institutions should be able to earn money since these vocational nurses studies have to be funded.

In contrast, the CNA asserts that not all secondary-level nurses should be obliged to complete higher education nursing studies – suggesting negotiating with the EU to secure automatic harmonisation with the Directive for those nurses who completed secondary-level nurse training more than five years ago and have practised for three years; all other secondary-level nurses should undertake a bridging course financed by the Croatian government. The Croatian Nurses Chamber sees no need for such bridging courses but the CNA strongly asserts that the future of nursing in Croatia is dependent on these if it is to meet the urgent need for nursing educators and curricula that comply with EU standards.

It could therefore be argued that a divide and rule strategy was employed as a mechanism to prohibit change (C4 Political Scientist; C17 Nurse Leader). As an executive board member of the EFN, the CNA applied for Commission support through the TAIEX capacity building session in 2007 and 2009. These capacity building sessions aimed to reach consensus on moving nursing

education from secondary to higher-level education, bringing together key health stakeholders and conflicting stakeholders to jointly identify the main challenges when transposing Directive 2005/36/EC into a national Nursing Act. As described in a letter from the President of the CNA to the President of the Croatian Nursing Chamber:

> "We wish to gather all decision-makers in the field of nursing. We consider the Croatian Nurses Chamber an important and unavoidable factor in the field mentioned. Therefore, we suggest that you delegate four members of the Chamber concerning the best interests of the nursing profession and in order for them to contribute to quality and constructive discussion in the best possible way." (BR, personal communication, 18-12-2006)

The 2007 workshop brought together 60 participants from governmental and professional organisations as well as international experts and TAIEX representatives. Issues raised by the participants were discussed in four working sessions with the aim of producing recommendations shared and supported by all participants.

The outcome of the capacity building seminar was the development of a national nursing strategy, setting out and agreeing a common professional agenda with the surrounding countries of Bosnia and Herzegovina, Montenegro, Former Yugoslav Republic of Macedonia and Serbia. The recommendations were sent to the Prime Minister of the Republic of Croatia; Minister of Health and Minister of Social Welfare Policy and Youth; Minister of Science, Education and Sports; Secretary of State for European Integration; and the Commissioner for Enlargement of the European Commission relate to the need for a TAIEX peer review. This would involve all stakeholders in designing a new Nursing Act; bringing the general educational system in line with European standards and the regulatory system for nurses and midwives in line with European requirements; and developing and executing a clear implementation plan.

The TAIEX peer review took place in 2008. Formulation of the shortcomings of the nursing education system indicated that harmonisation was incomplete, implying that Croatian nurses would not be recognised automatically in the EU and therefore would be unable to work as general care nurses in other MS. Croatian nurses would no doubt be able to conduct certain work in these health-care systems but only as nurse assistants under supervision.

A similar workshop took place in 2009, focusing on the same stakeholders and making a clear recommendation to the Minister of Health and Social Welfare regarding: "The urgent need to lift the level of education of nurses in Croatia in the sense that the basic level of nursing education must be a bachelor degree" (BR, personal communication, 26-10-2009). This workshop led to a mutual understanding about the urgent need for common action to lobby governmental institutions to change the negotiating position and to strengthen mutual cooperation between nursing stakeholders in Croatia.

7.2.4 Intergovernmental structures

Following up on the TAIEX capacity building seminars, a meeting was held between the Ministry of Foreign Affairs and European Integration, Department for Analysis of Legal System Harmonization and the main Croatian negotiator and members of the negotiation team.

As a result of the professional association's continuous advocacy work and the multi-layered awareness approach, nurse leaders from the CNA and the nursing union were appointed members of the Government Agency for Vocational Training and, as such, were invited to participate in the Sectoral Council for Health and Social Welfare. The Sectoral Council's remit is to define professional qualifications' standards; analyse existing and future competencies; promote employment opportunities in the health and social welfare sector; propose the establishment of curricula and relevant institutions for vocational education; and set the profiles of health workers to be educated in the health and social sector.

During these meetings, the CNA became aware of the formation of a professional committee comprising members from the Ministry of Health, the Ministry of Education, the Agency for Vocational Education and Training and principals of nursing education institutions. This committee led the preparation of the new national nursing educational curriculum which was completed in October 2009 and planned for implementation in the 2011/2012 academic year.

The Croatian government argued that implementation of this new curriculum would imply Croatia’s compliance with the *Acquis*. Consequently, Chapter 3 of the *Acquis* was provisionally closed on 21 December 2009.

In January 2010, the Ministry of Education hosted a meeting of representatives of the CNA leadership, the Ministry of Health and the Agency for Vocational Education and Training to discuss this proposed national nursing curriculum. The CNA clearly stated its dissatisfaction and disagreement with the curriculum content and the fact that all the actions of governmental bodies in Croatia to date had not allowed nursing education in Croatia to be harmonised with the European Directive.

7.2.5 Summary

Three principal mechanisms enabled nurse leaders to engage in the EU accession policy process – (i) the Commission Comprehensive Monitoring Reports on which the political decisions are taken in the Council and European Parliament, (ii) the TAIEX peer review reports indicating the major challenges for achieving harmonisation with EU Directive 2005/36/EC; and (iii) the TAIEX capacity building seminars. Croatian nursing leaders employed the latter to their full potential.

The selection of physicians and lawyers as negotiators, decided by the Croatian government signing the EU accession agreement, put the nursing leadership in a weak position as these lawyers and physicians negotiating the minimum requirements for nursing education believed nurses are enough educated, at vocational level. However, the capacity building mechanism did empower the nursing leadership in Croatia. The multi-layered approach led to the nursing leadership's engagement in the Government Agency for Professional Vocation; the Sectoral Council for Health and Social Welfare; and the newly designed professional committee leading the preparation of a national nursing educational curriculum in line with the European Directive.

Chapter 3 of the *Acquis* was closed on 21 December 2009, all *Acquis* chapters were provisionally closed in December 2010 and the Croatian Government signed the Accession Treaty in 2011. This implies that the Commission had agreed that the Directive on MRPQ, as part of Chapter 3 of the *Acquis*, had been transposed into a new Croatian Nursing Act. According to nurse leaders interviewed, this was not the case.

Nursing leaders hope that the new government's Minister of Health (also a physician) and the Prime Minister will be more attentive to the CNA's arguments for upgrading nursing education prior to EU accession on 1 July 2013. Knowing that all chapters of the *Acquis* have been provisionally closed, the European Commission agreed a second peer review. The Commission

appointed a Spanish nurse and an Irish nurse competent in the field of regulation to make a new evaluation (May 2012).

The next section examines the conflicting agendas and the policy outcomes within the context of the spectrum of different stakeholders engaged in the EU accession policy process. These include the Commission, the Croatian Government and the different nursing constituencies – the nursing regulator, the nursing union and the professional association.

7.3 Impact of EU accession policy process

Following on from the policy context in which nurse leaders and policy-makers grew up during the Titoist Communist regime and the mechanisms that the nursing leadership employed to engage and impact on the EU accession policy process, the legislative and professional outcomes can best be explained by the nursing community stakeholders' interests and influence on the EU accession policy process.

7.3.1 Legislative compliance

Croatia submitted its formal application for EU membership in February 2003 but due to the failure to deliver General Gotovina to the ICTY the European Council decided to postpone EU accession negotiations till October 2005. In December 2010, Croatia provisionally completed all negotiations on compliance with EU legislation, including Chapter 3 in which the Directive on MRPQ is located. With the closure of Chapter 3 the Croatian government and the European Commission are of the opinion that the provisions of Directive 2005/36/EC on the exercise of the profession of nurse responsible for general care are integrated in the new legislative act. At the end of June 2011, the Commission announced the conclusion of six years of negotiations over Croatia's entry into the EU.

7.3.1.1 Benchmarking minimum requirements of the Directive

The first key concern relates to enrolment in secondary nursing schools. This provides for completion of eight years of primary school education and so students begin their training at the age of 15. Consequently, this programme does not meet the ten-year minimum entry requirement for general education as set out in Directive 2005/36/EC. Moreover, with the duration of four years

the curriculum does not meet the second minimum criteria of 4600 hours as set out in Article 31 of the Directive.

The curriculum contains subjects of general education – including foreign languages, Latin, mathematics, history, geography and physical education. Several nursing subjects (e.g. psychology, clinical medicine, pathology) have been introduced since 2006 but the ratio between theory and practice is unclear since the nurse training course is combined with a general education programme. The curriculum also has several shortcomings in its content and does not contain the subjects of the training programme presented in Annex V of the Directive. Practical training under supervision in hospitals is included in the curriculum (mainly during the summer months) but a student nurse cannot operate independently before the completion of the one-year internship in several clinical areas. This internship period cannot be considered as a part of the nursing education programme. A legacy from the Communist era, on completion of secondary school training students are required to pass a final state examination before registration as a Nurse – Medical Technician. This indicates that Croatian nurses lack professional autonomy and operate mainly under the supervision of a doctor. This was described by a Croatian policy-maker:

> "Although the relation between the nurses and doctors is very good, nurses are not working autonomously. Nurses are supervised by the doctors. Nurses cannot do anything on their own." (C17 Nurse Leader)

All Croatian nurses who have completed this programme over the last ten years will have difficulty obtaining recognition of their professional qualifications and consequently will not be able to move within the principle of mutual recognition between MS. The TAIEX experts from Hungary and Cyprus therefore took the view that the Croatian government should abolish this secondary-level nursing education and develop the higher level of education to reach the minimum standards set out in Directive 2005/36/EC.

These views are shared by many nursing stakeholders:

> "Croatian nursing education has a very low standard and nurses do not assume personal responsibility for the nursing care process ... although we need these secondary level nurses, we cannot call them Directive 36 nurses." (C5 Nurse Leader)

Nurse training at post-secondary level requires 12 years of general education and complies with the first minimum requirement of Directive 2005/36/EC. The curriculum follows a three-year study programme in which the curriculum topics are in accordance with the subjects of the training programme presented in Annex V of the Directive. However, it is not clear whether this curriculum fulfils Article 31, 6(b) which requires an assurance that students have acquired "sufficient knowledge of the nature and ethics of the profession and of the general principles of health and nursing" (C8 Nurse Leader/Policy-maker). For instance, in the Osijek curriculum the term 'Clinical Medicine', 'Fundamentals of Health Care' and 'Health Care Process' do not ascertain that these courses contain nursing care taught by nurses. Furthermore, the ratio between theory and practice is not in line with the Directive, although the theoretical part is taught by higher-level nurse graduates who have also been educated in teaching methodology. In particular, the total of 2760 hours ascertained during an assessment in the education facilities in Rijeka and Osijek does not meet the 4600 hour requirement of the Directive. Nurses' higher-level education therefore presents limitations regarding both the content and the number of hours of the theoretical part of the curriculum. Although criteria based on hours of study, compared to competency based curricula, can be criticised, overall there is a movement in the EU towards lowering down the total hours and especially the clinical practice having difficulty in reaching 2300 hours. Clinical supervision of nursing students takes place in school, in hospital laboratories and in health-care institutions at primary, secondary and tertiary health-care facilities. Students are supervised by experienced higher-level educated nurses and by mentors who are also higher-level nurse graduates.

Although having passed a one-year internship period prior to passing the final state examination in order to gain a nursing baccalaureate and a licence to practice from the regulatory body, the internship period cannot compensate for the hours of clinical practice that are missing in the curriculum.

The Croatian Ministry of Health argue that the relationship between the two training programmes at different educational levels and the responsibilities attributed to their graduates did not need to be specified in the national Nursing Act, as both levels provided access to the same tasks. This contrasts with many MS which have different levels of nursing education in which only graduates of higher-level training are entrusted with more responsibilities, and have greater independence

to perform tasks. Failure to differentiate between different levels provides little incentive for nurses to qualify at the higher level.

Furthermore, the capacity building seminar reports show clear stakeholder agreement that secondary education in Croatia is not structured to provide the vocational or higher education that nursing requires. Echoing the appointed TAIEX experts, the nurse leaders interviewed believed that there were insufficient resources (in terms of learning material) for this level of education in the secondary education system, and teachers had insufficient training for effective delivery of such training.

Some participants also noted that the educational reforms implemented by the Croatian government focused on the duration of training but gave no attention to the content and educational methodologies required to deliver the curriculum effectively. Participants of the TAIEX capacity building session agreed on the need to teach the science and art of nursing within a multidisciplinary setting and to incorporate research competencies into the curriculum. This would generate graduates who are evidence based in their practice and equipped to undertake lifelong learning.

It is concerning to read that:

> "The students in secondary nursing schools are told that they will receive a diploma in accordance with the EU standards, recognised as a nursing diploma abroad but which is not in accordance with Directive 2005/36/EC." (C10 Psychologist)

This misleading information can have serious consequences for the free movement of these graduate nurses and their level of employment in another EU MS.

7.3.1.2 Institutional impact

Compliance with Directive 2005/36/EC forms part of the *Acquis* chapter on transforming the national economy into a functioning single market economy based on the free movement of goods, persons, services and capital. As in Romania, Croatian governments considered this to be: "an easy thing to do" (C10 Psychologist; C17 Nurse Leader; C4 Political Scientist).

In contrast to Romania, the data suggest that the Croatian Ministry of Health welcomed Commission support for organising capacity building seminars. However, given their opinion that compliance had been achieved already, the Ministry did not take up any of the outcomes. This

strange ambivalence can be explained by the fact that the Secretary of State for Health was also a physician, and could not be convinced that the entire Croatian nursing workforce needed to be upgraded to meet EU standards. Furthermore, this view suggests the intrusion of an element of doublethink which raises the need to consider what commitments given might actually represent in practice.

Nevertheless, the TAIEX capacity building seminars led to nursing leaders' engagement in governmental structures (e.g. Government Agency for Professional Vocation) and thus an ability to influence the design of policies. The nursing leadership received an official invitation and information on the first Sectoral Council for Health and Social Welfare. Formed by the Ministry of Education, Science and Sports on 28 April 2009, the Sectoral Council for Health and Social Welfare defines the needs for professional qualifications; analyses existing and future competencies; determines the context for professional qualification standards; promotes the health and social welfare sector and employment opportunities within this sector; proposes the establishment of curricula and relevant institutions for vocational education and sets the profiles of health workers to be educated in this sector.

Introduced by the Ministry of Science, Education and Sports in February 2009, the Vocational Education and Training (VET) Act includes Article 5(3), stipulating that:

> "Exceptionally, participants of programmes for acquirement of medical qualifications, after finishing a two-year general part of education, receive a certificate whose content and form is determined by the Minister." (C16 Policy-maker)

This newly adopted Act ensures that nurses in Croatia have sufficient (10) years of general education to comply with EU standards. The VET Development Strategy (adopted on the session of Government of the Republic of Croatia on 31 July 2008) and the VET Act (Official Gazette 30/09) provide a legal framework for mutual recognition of qualifications. Furthermore, the Law on Regulated Professions and Recognition of Foreign Professional Qualifications (Official Gazette 124/2009), and Law on Healthcare Strategy (Official Gazette 72/06) were adopted with the aim of adjusting the education and competences of nurses and midwives to comply with the regulations of Directive 2005/36/EC.

During these meetings, the nursing leadership became aware of the formation of a professional committee comprising members from the Ministry of Health and Social Welfare; Ministry of

Science, Education and Sports; the Agency for Vocational Education and Training; and principals of nursing education institutions. This committee prepared a national nursing educational curriculum which should be in accordance with the European Nursing Directive. This curriculum was completed in October 2009 with the intention that it should be implemented in the 2011/2012 academic year. The Croatian Government believed that implementation of this curriculum would satisfy the Commission. Indeed, Chapter 3 of the *Acquis* and the harmonisation process was provisionally closed on 21 December 2009.

On 8 January 2010, the Ministry of Education, Science and Sport invited representatives of the CNA; Ministry of Health and Social Welfare; Agency for Vocational Education and Training; Department for Vocational Training and Department for Higher Education of the Ministry of Education, Science and Sport to a meeting on the topic of a new national curriculum. During the meeting, the CNA leadership clearly stated dissatisfaction and disagreement with the content of this curriculum and the fact that, to date, all the actions of Croatian governmental bodies had not allowed nursing education in Croatia to be harmonized with the European Nursing Directive. The nursing leadership also pointed out that provisional closure of Chapter 3 does not mean that harmonisation with Directive 2005/36/EC has been achieved (C17 Nurse Leader; C5 Nurse Leader). One nursing leader concluded by saying that: "it is necessary for nursing education in the Republic of Croatia to be set to bachelor degree as the basic nursing level of education" (C17 Nurse Leader).

Lack of compliance with the European Directive implies that Croatian nurses would not be fully recognised in other EU MS and therefore their free movement as health professionals would be jeopardised – Croatian nurses could move freely in the EU, but not as nurses. Therefore, CNA leaders pushed the agenda to establish the first faculty of nursing at the Catholic University, despite some opposition within the CNA membership: "A nurse educated through the secondary school is performing very well and is very competent, but we haven't yet the evidence" (C1 Nurse Leader).

As agenda-setting for Croatian nursing education focusses on moving from vocational training to higher/university level education, one important topic is the creation of a cadre of nurses qualified to teach nursing at higher/university level, with the expectation of developing a European exchange programme for nurse professors. This idea was proposed by the CNA nursing leaders

following the recommendation of the TAIEX peer review. Prior to accession, CNA leaders and the Centre for Promotion of European Standards in Health proposed that the Health and Education Minister's agenda should include the need to attract foreign experts as educators in the newly developed universities for nursing. Development of nursing education at university level implied a focus on investing in 'teaching the teachers', with European and international support.

> "We have received help from the USA and our union leaders and members have been educated, and the importance is to have educators which educate further our members. And this is a strong point when we negotiate with our government." (C1 Nurse Leader)

7.3.2 Professional achievements

Next to the legislative compliance with EU legislation, the Directive on MRPQ can boost professional development based on Article 31 of the Directive 2005/36/EC. Themes such as 'strengthening advocacy' and 'strengthening leadership' indicate the challenges ahead.

7.3.2.1 Strengthening advocacy

Due to EU accession, nursing leaders' position, especially the regulatory and governmental positions, have been strengthened by the design of a new Nursing Act in contrast to the professional nurses association. Therefore streamlining the different roles creating tension and power conflicts becomes a major challenge for the nursing community engaging in policy processes at national and European level.

Knowing that all chapters of the *Acquis* had been closed, the President of the CNA (also Vice-President of the EFN) pleaded with the EFN Executive Committee to take action to address the need for a high-quality health-care system in Croatia requiring high-quality nurse education at preliminary and higher education level in compliance with the requirements set out in Directive 2005/36/EC.

Through the EFN, the Croatian nursing leadership met informally with the Commission to express their concerns about the political decisions taken on compliance with the *Acquis*. The following issues were raised.

1. Basic nursing education in Croatia still commences at secondary vocational school. Its content and educational methodology has neither changed significantly nor improved, despite recent attempts at reform.
2. Since the 2010/2011 academic year, professional nurse education has begun in the third year of secondary vocational school so students study general subjects during the first two years of education. This pattern of education is out of line with general education provision for the rest of Croatia. Hence, nurses trained in this manner will de facto be excluded from higher education facilities because they lack the preliminary education required, and therefore cannot sit the state entry examination.
3. As a further consequence of the reforms aiming to achieve harmonization with Directive 36, the required minimum of 4600 hours of theory and practice have been crammed into three years of secondary school. In Croatia, young people aged between 16 and 19 are now expected to carry a study load not seen elsewhere in the EU until a student is at least 18. As a consequence, regulators across the EU may have major reservations about granting automatic recognition to such nurses. This may lead to extensive legal challenges which could be avoided by appropriate action prior to EU accession. A new peer review is therefore advocated.
4. Transfer or entry to other secondary schools is impossible for students who give up their education in secondary vocational nursing school after the second year (having studied only general subjects). Similarly, students in other secondary schools who would like to continue their education in a secondary vocational school for nurses (general nurse education) cannot transfer after the second year of study. This example of the lack of logic in existing nurse training arrangements in Croatia provides further evidence to support the case for the Commission to make a thorough review of the current arrangement.
5. The reforms being implemented by the Croatian government have focused only on the duration of training and not on the content, nor on the educational methodologies required to deliver the curriculum effectively. There is still time to redress this situation which will require nurse education to be shifted so that the science and art of nursing can be taught in multidisciplinary settings. This also needs the research competencies of a higher education faculty capable of generating graduates who are evidence based in their practice and equipped to undertake lifelong learning. This requires the teachers to be adequately trained in order to deliver such training effectively.

6. The Nursing Act in Croatia is insufficiently explicit as it draws its powers from pre-existing legislation. This poses challenges to transparent implementation and may hinder free movement of nurses. The Commission needs to ensure that the legal framework for the training and regulation of nursing is as transparent as possible.

On the basis of these arguments, and since the arrival of a new government in 2011, the Croatian nursing leadership, with the support of EFN, has focussed its advocacy on encouraging the Commission to re-examine Croatian nursing education. Consequently, a second peer review took place in 2011. Although the negotiating parties – the Commission and Croatian government – argue harmonisation is completed and nurses will benefit automatic recognition, the competent authorities from other EU Member States will not trust the mutual recognition for Croatian nurses as no bridging courses were installed during EU accession addressing the major concerns as set out in the Taiex peer review reports. As was the case for the Romanian nurses, the Commission did not include any derogation in the Directive for Croatian nurses. No doubt, Croatian nurses will be able to conduct certain work in other health-care systems but only as healthcare assistants under supervision of a registered nurse.

The failure to comply with the definition of general nurse given in Directive 2005/36/EC indicates that Croatian accession to the EU is a complete policy process, but the lack of trust between competent authorities will have serious implications for the rest of the EU. Without confidence in the systems adopted in Croatia, harmonisation will not be achieved and automatic recognition becomes impossible.

Based on these findings it is argued that the Commission should be hold responsible and accountable for not taken seriously the formulated recommendations made by two regulatory body nursing colleagues analysing the Croatian situation prior EU accession. It is even worrying, from a legal perspective that there is no completed peer review for the Croatian nursing education as the two peer review reported were never signed off by the relevant Croatian government departments which questions the relevance of provisionally closing chapter 3 of the Acquis. We therefore have a situation where the peer reviews formulate clear recommendation while the Croatian government none response blocked the process of reform. In consequence, there is now a very strong case for not recognising Croatian nurses in the wider EU. It can therefore be argued that TAIEX is purely an academic exercise without any political implications.

Action is needed to address this part of the decision-making process associated with closure of the relevant Accession Treaty chapters. The Commission needs to re-examine the current proposals and advise the Croatian government on the steps necessary to achieve compliance. Such action has not occurred.

7.3.2.2 Strengthening leadership

Based on the analysis of the interviews, a number of indicators of good practices were identified with regard to political leadership. These indicators formulated by the participants' intend to contribute to successful policy outcomes according to the participants. Although these political leadership indicators as formulated by the participants do not appear context specific, they highlight their experiences to achieve successful policy outcomes overall.

The indicators can be summarised as follows:

1. *Facts and credibility*. The nursing leadership acquired knowledge on how to establish nursing within politics and what knowledge is needed in order to be heard by politicians. Therefore, position statements, preferably joint positions with other stakeholders, are central when advocating for nursing and to address the consequences of public policies. But these statements must present more than just "facts" as various stakeholders will interpret facts in a variety of ways. Clear positions shape policies but only to the extent that politicians and citizens trust the nursing profession data and views. Demonstrating that the professional advocacy actions have a scientific base is one of the ways the nursing profession increases its credibility and public trust: "Credibility is a very important characteristic of a nursing leader. Every leader has to have credibility" (C5 Nurse Leader). Informants perceived transferring "*my personal knowledge and experience*" to a person with influence in the policy process (e.g. negotiating team members) as an essential indicator for success, next to building trust with the negotiators. As expressed by a nurse leader:

> "There are people who made the Prime Minister realize that I am the person he should count on when talking about nursing" (C8 Nurse Leader/Policy-maker).

2. *United voice for nurses and nursing*. The government and policy-makers have become aware of what nursing is about and what nursing means in Croatia. This was achieved by setting out their common strategies and tactics based on their business case. As findings indicate, the TAIEX capacity building facilitated this process although the nursing regulator and professional association were divided on how nursing education should evolve to comply with the European Directive.

> "I am one of the persons who started the work on the Croatian Nursing Act and I participated in the creation of the Nursing Chamber. I saw the nursing then through the three strong independent but connected institutions." (C5 Nurse Leader)

Participants indicated the importance of establishing a leading government nursing department that co-ordinates the changes needed in nursing education and clinical practice. Interviewees argued that this department should be led by a chief nursing officer (CNO) employed by the Ministry of Health and Social Welfare. However, ministerial regulations require holders of this post to have a university degree – and this is not available in Croatia. As such, the united voice for nurses and nursing is driven from the 4 key positions at National level: the President of the Professional Nurses Association, the Head of the Nursing Regulator (as an independent organisation), the Nursing Union leader and the Chief Nursing Officer. Mainly 4 ladies running the united voice.

3. *Stay in the field*. An impactful strategy for success was believed to be in the system and not beyond the system. This is one of the main reasons why participants perceived the nursing profession to have a privileged position in policy-making and politics – nurses are frontline workers dealing with reality. Most policy-makers, specifically political scientists, consider that strengthening fieldwork is key for successful policy development and political engagement. The nursing profession has the advantage of working amongst citizens and the best way to shape policies is to be with, and go among people to see how policies can be improved and implemented. Many participants argue that the more nurses and their policy ideas can show widespread support from patients and consumers, the greater the chances of influencing the health agenda are and the more successful policy outcomes can be achieved.

> "The nurses are a big group and if they are educated at a high level they become a strong force and will take the lead in governing the health-care system. If governments do not have the nurses with them, they will face major difficulties to implement what they want to do."(C12 Civil Society Advocate)

4. *Communicate with the media to inform the public*. Nurses can achieve a more powerful position by providing the media with information to present all the facts to their readership. This places huge responsibility on nurses' professional associations, unions and regulatory bodies to ensure that they communicate with the public by means of simple and concise joint messages. Words matter and nursing leaders must be conscious of how they talk about issues. Nursing leaders will not survive the heat of political debate if they are not able to convey the essence of what they are advocating for.
5. *Taking concrete actions*. Participants highlight that leaders face an incredible array of demands and needs and therefore it is difficult to focus their efforts and energies. Successful nursing leadership requires good intuition (a strong trait in nurses) to be able to distinguish between what is important and what is not. The focus must be concrete policy actions that lead to concrete policy outcomes which are recognised by the public as relevant.
6. Keep *'the wind on your back'*. Interviewees' experience has highlighted that this is important for progress and eventual success. The 'political wind' can change suddenly after elections (as in 2011) and so participants stress the importance of building alliances with civil servants working for politicians, and having patience to wait for the right moment and the right politician to be elected.

> "The politicians in power change but the civil servants in the ministry stay. When government changes, there is always the period of reorganisation during which one cannot push the idea and then in one moment all the things come in place and you end up with the politicians who do have a desire and possibility to make changes." (C15 Politician)

7. *Know the 'movers and shakers'*. Building alliances, soliciting key players' opinions on important issues and starting discussions with the public are considered important for

moving policy outcomes in the right direction. Movers and shakers can be identified through their publications and by people within civil society who recognise the key players. The ability to identify key players before they become political leaders is an important leadership skill.

8. *Think politically*. Participants indicated that policy think-tanks are essential for creating political debate in which nurse leaders should take the lead concerning health policies. Nurses' advocacy for patients' rights, quality of care and safety within the health-care system provides a strong basis for leading these policy debates and promoting arguments to develop and adopt policy proposals.

   Increasing citizen engagement in the act of governance can be achieved if nurses, frontline workers, become more politically engaged and lead policy debates from a gender perspective.

Participants have a clear view on how success would look like if nursing leaders were in a position to develop these leadership skills. Nevertheless, participants equally stressed that the nursing profession needs more nurses, more frontline workers, becoming politicians. Participants stressed that "we need nurses in our Parliament" (C2 Politician) and "as nurses are part of the health-care system, nurses need to be part of the policy process in Parliament" (C21 Physician/politician). Participants perceive nurses' advocacy for patients' rights, quality of care and safety within the health-care system as a strong basis for political leadership on the condition 'nurses think politically', 'nurses speak with one voice', 'nurses become part of the movers and shakers', 'nurses create opportunities', 'staying realistic' while 'communicating a clear message to the public' and 'being trustful'.

7.3.3 Summary

In summarizing the identified themes related to legislative and professional outcomes, it is important to note participants' disagreement on the provisional closure of Chapter 3 of the *Acquis*. Although the Commission's monitoring reports indicated poor progress in the area of mutual recognition of professional qualifications and the 2010 progress report identified significant weaknesses still to be addressed, the Chapter 3 became provisionally closed in December 2009.

The legislative outcome reflects the views, interests and influence of the Secretary of State for Health and the senior nursing official who considered that nursing education needed no upgrading

in order to comply with Directive 2005/36/EC. This will impact on the confidence in the system of mutual recognition of professional qualifications which can only be achieved when all Croatian nurses have automatic recognition. Currently, nurses who graduate prior to 2013 will be unable to work as nurses in all EU MS. At the time of writing (September 2012), the Nursing Act draws its powers from pre-existing legislation in Croatia and is not in compliance with Directive 2005/36/EC. This hinders free movement of nurses and therefore the European Commission needs to ensure that the legal framework for the training and regulation of nursing is harmonised with EU legislation prior to EU accession in July 2013.

Although the legislative changes did not achieve their expected outcomes, the Croatian case study findings show that the Croatian nursing education moved prior EU accession towards developing nursing as a profession by developing an Nursing Act regulating the nursing profession and locating the nursing education at university level and as such complying with EU legislation. The EU accession policy window enabled the Croatian nursing leadership to influence the professional and political agenda although agenda setting was difficult due to diverging views on compliance within the nursing community.

The compliance negotiations for EU accession were held exclusively between the Croatian government and the European Commission, but the findings show that nursing stakeholders' views, interests and influence set the level of acceptance of the legislative outcome and determined the extent and direction of engagement with the policy process. It can be argued that the EU accession process was therefore a policy window for nursing leaders seeking political influence to create a new Nursing Act compatible with Directive 2005/36/EC.

Findings indicate that the Commission's support for the organisation of capacity building seminars strengthened the nursing leadership, enabling leaders to engage in different governmental structures and thus influence the design of policies. The advocacy capacity of the Croatian nursing leaders increased and led the Commission to re-examine the Croatian Nursing Education Act in 2012.

These outcomes were facilitated by the Croatian nursing leadership establishing clear ideas on what successful leadership should look like – recognising that 'facts and credibility', 'a united voice', 'staying in the field', 'taking concrete actions', 'communicating clearly with the public', 'keeping the wind on your back', 'knowing the movers and shakers' and 'thinking politically' helped

them to achieve better policy outcomes. This suggests that good networking and speaking with one voice for nurses and nursing is essential. Based on these eight identified criteria for successful leadership, it is also concluded that nurses need to become politicians.

7.4 Conclusions

The findings related to the study objectives emerged in three sets of data: the context, the process and the outcomes.

In the policy context, four indicators – 'double identity', 'societal status', 'collective values' and the 'Balkan War' – helped the Croatian nursing leadership to develop their influence on the EU accession policy process. Two other indicators – 'public health medical model' and 'occupied civil society' – made it difficult for the nursing leadership to push for legislative and professional change during the EU accession process. Nevertheless, the Croatian nursing leadership became eager to enter EU accession and was perceived by many participants to be a healthy voting constituency.

Findings referring to the process indicate that nurse leaders mainly employed three mechanisms to engage in the EU accession policy process – the TAIEX peer review reports indicating major challenges to achieve harmonisation with EU Directive 2005/36/EC; the TAIEX capacity building seminars, which Croatian nursing leaders employed to their full potential and the influencing of the Commission Monitoring reports through EU MS politicians in the Council and European Parliament. The capacity building mechanism empowered the nursing leadership in Croatia and led to engagement in the Government Agency for Professional Vocation, the Sectoral Council for Health and Social Welfare and the newly designed professional committee leading the preparation of a national nursing educational curriculum in line with the European Directive.

For the achieved outcomes, findings indicate that the Nursing Act developed is not in compliance with European Directive 2005/36/EC and will hinder free movement of Croatian nurses in the EU. From a professional perspective, the EU accession process facilitated the Croatian nursing leadership development of clear ideas on what successful leadership should look like – believing that 'facts and credibility', 'staying in the field', 'taking concrete actions', 'communicating clearly with the public', 'keeping the wind on your back', 'knowing the movers and shakers' and 'thinking

politically' are important components of their leadership that helped them to achieve better policy outcomes. Nevertheless, speaking with one voice for nurses and nursing was a major challenge that weakened their impact. Based on these eight identified criteria for successful leadership, it is also concluded that nurses need to become politicians.

Chapter 8 Discussion

The purpose of the discussion chapter is to pull together the findings in a comparative way and to integrate the findings with the several theories as set out in the thesis, next to critically evaluate the findings of both case studies in the light of my insider-outsider position.

This chapter considers the degree to which the nursing profession in Romania and Croatia employed the EU accession process as a policy window to advance a legislative and professional agenda. The findings relate to (i) the views and experiences of participants in terms of their exposure to Soviet-style socialism context and the manner in which this shaped their engagement with the EU accession policy process; (ii) the mechanisms employed to bring about change; and (iii) the legislative and professional outcome patterns taking many forms (Pawson &Tilley, 2004).

The findings suggest that outcomes differed and the dynamics which drove the policy advocacy varied between the countries. This can be explained in part by the pre-democratic contexts derived from the Romanian and Croatian ethnographic accounts which revealed the different texture of policy settings, especially for those Member States (MS) moving from communism to democracy. These dynamics relate to the desire for autonomy from the medical profession, building capacity within civil society, becoming a political voting power and being able to move freely as a European nurse. Comparison of the case studies revealed the differences between the Ceausescu regime in Romania and the more liberal Tito regime in Croatia. These impacted on the ways that the nursing leadership engaged with, and influenced, the EU accession process.

Following the discussion of the pre-democratic contextual factors impacting on the policy process and outcomes, the chapter continues by analysing the available Commission's mechanisms employed to achieve compliance with Directive 2005/36/EC. In contrast to the TAIEX peer reviews and the TAIEX capacity building seminars, the Commission's comprehensive monitoring reports are insufficiently robust to compensate for the identified legislative and professional weaknesses as set out in the TAIEX peer review reports. Appointed once as a TAIEX expert for Romania in 2004, and selected as expert in EU law on mutual recognition of professional qualifications to speak at the capacity-building programme in Croatia, my insider-outsider position helped to understand the complexity of the EU accession policy process and the sensitivities between state and non-state stakeholders in relation to the achieved outcomes.

Although the risk that the importance of TAIEX can be overstated due to my participant status, the findings show that the absence of multi-level governance – as a mechanism involving different institutions and stakeholders with diverging views and perceptions – impacted negatively on the achieved outcomes. However, the TAIEX peer reviews and the TAIEX capacity building seminars (the latter used only in Croatia) provided the opportunity to advance nursing as a profession in a medically dominated policy and post-Communist Semashko working environment. Although the long-term or sustained impact in Romania became visible after a political agreement on the modernisation of Directive on MRPQ in 2013, findings show the importance of TAIEX to inform the nursing community on the challenges of compliance.

This chapter therefore discusses further the evidence for long term and sustainable impact EU accession has on the development of the nursing profession in Romania and Croatia (Pawson &Tilley, 2004). The legislative and professional outcomes relate to a newly design nursing legislation and the establishment of a nursing regulatory body, in Romania and Croatia. As such, findings provide evidence for the professionalisation of nursing through the established procedures for recognition of qualifications, setting out the professional rights and responsibilities as well as mechanisms for public accountability with the design of a code of conduct (Lester, 2010). However, reviewing the nursing curricula in compliance with the EU Directive 2005/36/EC identifies key challenges for professional development with diverging views on compliance, the governmental complacency attitude inhibiting upgrading the nursing education in both countries prior EU accession. Although not achieved before entering the EU, both governments started planning bridging courses post- EU accession. Based on these comparative case study findings on sustainable outcomes, it can be argued that EU accession was not a destination but rather a starting point for Romanian and Croatian nursing education to be upgraded towards European standards as set out in Directive 2005/36/EC.

The discussion chapter concludes by embedding the interpretation of the comparative findings in reflexivity which played due to my insider/outsider position an important role in the design and process of the research study. Although positivists encourage researchers to remain 'outside' the world studied, so as not to lose 'objectivity' and 'bias' the findings (Fraser, 1997; Calhoun, 1994; Mbilinyi, 1992; Sherman & Webb, 1988), my job as Secretary General of EFN made it impossible for me to remain detached and neutral throughout the research study.

8.1 Pre-democratic context

The comparative synthesis of the Romanian and Croatian findings indicates that engagement with EU accession by the respective nursing leaders relied on the behaviour and skills developed and acquired during their pre-democratic regimes. Findings confirm Wildavsky views that the political culture, the regime, predicts individual leadership, more than any other factor, including their race or gender, socioeconomic status, political understanding or even party affiliations. The findings indicate the period of regime change was a critical juncture in both countries, although there was no clear break from the past as the assumptions and beliefs related to the Soviet Semashko model of health-care delivery continued with the move towards democracy. Important expectations with respect to the medical assistance model of nursing care were set during the Communist regimes and continued to exist prior EU accession. These are still apparent in the way that the nursing leadership continued to operate when influencing politicians and policy-makers, who are mainly physicians. Therefore it can be argued that the uptake of the window of opportunities by nurse leaders' prior EU accession relates to the position of the masculine position ('the male doctor') towards the nursing profession, consisting of 92% of women (EFN, 2012). The 'medical profession' still builds its power on elitism, paternalism and authoritarianism with the tendency to control nurses and the nursing education preventing nursing becoming an autonomous profession (Davies, 2007).

Furthermore, findings suggest that outcomes are different and the dynamics which drove the policy advocacy can be explained in part by the pre-democratic contexts. Living through the Ceausescu and Tito regimes created a double identity in which nurse leaders developed their political antennae, their vigilance – described by participants as their "extra sensors" – since it was perceived that nobody in society could be trusted. Within the EU accession process, "fear and control" remained an issue capable of undermining the advocacy and leadership capacity. Participants referred to 'fear of the invisible enemy', being perceived to be a direct result of the regimes establishing the Securitate in Romania and the OZNA in Croatia, comprising special units encouraging individuals to spy and betray. Although Communism in Croatia was perceived as market socialism, nursing leadership (in both Romania and Croatia) learned how to cope with this control and fear and consequently learned how to operate within the political framework of the Semashko health-care system.

It can therefore be argued that resistance is an important feature of the nursing leadership. Clearly, the Romanian and Croatian nurse leaders did not switch off their critical sensibility, although tremendous human risk was involved in speaking up in the context of the controlling and oppressive system of the Communist ideology. It can therefore be argued that the advocacy capacity of the nurse leaders, characterised by 'being resistant', 'critical' and 'standing up for', strengthened the leadership skills to influence the policy-making process and hold Commission and governments accountable for non-compliance (Prakash & Gugerty, 2010; Baumgartner et al., 2009). Consequently, finding support Ezell (2001) and Edgett (2002) position that advocacy is a central function of leadership. Nevertheless, the extent to which the nursing leaders defined the model of professionalism and the goal towards which they want to achieve professionalisation have not been formulated. This vision and clarity, which was missing prior EU accession negotiation, is a key feature of leadership.

As all interviewees were born mid-1950s to early sixties, all survived the regime change in 1991 and moved into top leadership positions post the communist era. The developed leadership skills during the Communist era and developed networks of contacts impacted on the way the nurse leaders entered into EU accession negotiations. Manoeuvring in the Semashko health-care system implied building trusted networks of 'independent'-minded individuals which leadership skills were used to changing the nursing education and the profession when entering the EU accession period. The comparative findings suggest leadership is a consequence of regime, providing answers to "why we get the kind of policy, what kind of policy we want, and what we have to give up in order getting it" (Wildavsky, 1987).

The Croatian case study findings provide more evidence on how the consequences of the Communist regime created a nursing leadership advocating policy change within a largely patriarchal society (Davies, 2007). For both Romania and Croatia, international experience enabled nursing leaders to avoid being cut off from the rest of the world, using these contacts to develop 'their own' knowledge base as a means to advance their national nursing education agendas. As such it can be argued that the way nursing knowledge becomes institutionalised and discipline-specific methods, theories and knowledge are deployed to develop nursing as a profession (Krebs et al, 2005) impacts on the leadership and advocacy capacity of the nursing leaders. It is within this context that the Romanian and Croatian nursing leadership found that membership of the EFN became an important source of guidance and support – from the

Secretary General, from some EFN members engaged as experts in EU accession negotiations and from national networks within pan-European alliances established by EFN.

As Secretary General I was especially mindful of recognising the story of participants while acknowledging that my position did not prevent me engaging with fieldwork. As Secretary General of EFN, my missions to Romania and Croatia since 2002 have given me a more nuanced insight into the location of nurses, and nursing as a profession, within civil society.

The comparative findings indicate that civil society developed differently in each case. My insider-outsider position in both Romania and Croatia provided the opportunity to observe what was going on in high-level policy meetings which would not have been possible in solely researcher position (Walt, 2008; Sultana, 2007). The insiderness position (Labaree, 2002) facilitated exposing hidden and contrasting truths next to obtaining privileged information that otherwise would be unobtainable. An example of unobtainable information was that after the Balkan War, Communist Party leaders (powerful Croatian politicians) joined human rights NGOs and thus became part of Croatian civil society. To understand the complexity of policy-making, and as such the leadership needed to change or develop policies, it is important exploring the political context in which policy is designed. In contrast, during EU accession Romanian civil society was not populated with ex-Communist political actors. Findings show that the Romanian civil society became less biased with ex-Communist political actors. These findings are based on the impressive advocacy work of Romanian NGOs, especially in the area of health and gender, providing the evidence that strong leadership and advocacy capacity was operationalised in very difficult political environments. These findings show the importance of interest groups in public policy being part of civil society in order to probe the complexity of the policy-making process and continuously redesign strategies and tactics to reach the desired advocacy outcomes (Reisman, et al., 2007a; Guthrie, et al., 2005).

Following on from the factors enabling the nursing leadership to influence the EU accession policy process and outcomes, the analysis identified medical domination, next to nursing being divided in both countries, as the main barriers to the nursing leadership's impactful engagement in the EU accession policy process. The profession of nursing has not gained importance as doctors want to keep nurses (medical assistants) at their disposal.

Furthermore, findings from both case studies show that the policy-makers and politicians (mainly physicians) dealing with the EU accession negotiations – specifically Chapter 3 of the *Acquis* – had little understanding of the profession of nursing and as such designed policies inhibiting the development of the nursing profession.

These comparative findings support Anne Witz's (1992) research conclusions that a male dominated profession (medicine) inhibits the development of a women-dominated profession (nursing). Furthermore, the male and medical dominated policy environment with a Minister or Secretary of State negotiating EU accession with limited knowledge of nursing practice and education, helps to understand the lack of opportunity for the nursing leadership to exert influence on politicians and policy-makers who are mainly physicians and men. Add to this perspective the lack of 'fit for purpose' of the compliance mechanisms, the nursing leadership ability to influence policy-makers and politicians became even further constrained. It can be argued that the success or failure of professionalisation in the countries of Central and Eastern Europe depended to a large extent on nurses teaching nurses, nurses teaching nursing theories, nurses evaluating nursing students and nurses designing health and education policies in compliance with EU legislation. The poor representation of nurses in policy-making is one of the main reason why nurses should be encouraged to become policy-makers and politicians.

Both case studies provide evidence that no money is spent on nursing as the investment in nursing education implies losing the nursing workforce to another EU MS. Both the Romanian and the Croatian governments see EU accession as a brain-drain mechanism. In contrast, the evidence shows that it is more difficult for a Romanian physician to find a job in the EU and there is even a tendency for "doctors to become nurses so as to leave Romania". It is perceived to be frustrating for physician policy-makers to see nurses leaving. As such, reluctance to invest in nursing education and having a policy of exclusion by those in charge of funding might well be driven by the desire not to share available EU funds more widely. Similarly, professional and gender discrimination could also be a key issue with regard to developing nursing as a profession. These findings support the argument of Lester (2010) that professionalisation implies enjoying the recognition and respect of the wider community. Nevertheless, having and taking opportunities for free movement in the EU could be perceived as a privilege rather than a right by policy opponents.

The evidence shows that Romania's transition from a totalitarian regime to democracy was a more difficult experience than Croatia's. This was a result of weak political capacity and the party fragmentation which came with the regime change. The policy-makers and politicians interviewed perceived this lack of political capacity to design new legislation as a barrier to the nursing leadership engagement in the EU accession process. Nevertheless, they perceived nurses to be a healthy voting constituency although findings do not show that the nursing leadership converted much into political capital.

Transforming this opportunity into leadership capacity to advance nursing as a profession became part of the TAIEX capacity building. It can therefore be argued that the political and policy environment in which nursing became located isolated the nursing leadership from any political decision-making process. The nurse leaders reacted by developing their leadership capacity to keep on advocating for a nursing education and workforce to meet EU standards as set out in Directive 2005/36/EC. Interpretation of the comparative findings in the light of the literature shows that the contextual factors impacted more subtly in shaping the nurse leadership to influence policy processes and their outcomes.

The literature discusses how processes and context influence outcomes (Irmer, 2009; Druckman, 2007). Hence, a model in which contextual factors (inherited from a pre-democratic regime) impact on the way the nursing leadership influences EU accession processes is critically important to explain the achieved legislative and professional outcomes. Although the comparative findings lend support to the process-oriented approach, it is conceivable that most significant contextual factors were a stronger influence on the achieved outcomes given the limited engagement in the process. In other words, the medical-dominated Soviet Semashko model continued to impact on the mind-set of policy-makers, politicians and nurse leaders and thereby maintained the status quo. The policy and political science literature highlights the importance of Kingdon multiple streams framework (Zahariadis, 1999; Kingdon, 1984) emphasising actors' central role in the process of transforming information into policy outcomes. The model links three streams – problem, policy and political stream – opening "an opportunity for advocates of proposals to push their solutions, or to push attention to their special problems, [providing] opportunities for action of given initiatives" (Kingdon, 1995:120).

The leadership skills developed as a consequence of regime provide a better understanding of "why we get the kind of policy, what kind of policy we want, and what we have to give up in order getting it" (Wildavsky, 1987). Wildavsky (1987) argues in his *Cultural Theory of Leadership* that the political culture, the regime, predicts the political attitudes of individuals more than any other factor. The comparative case study findings support Wildavsky's argument that the pre-democratic regime helps to explain the policy process and outcomes that emerge.

Although study findings confirm Wildavsky attributing to the excessive importance of regime context, findings equally demonstrate the importance of other factors, such as medical domination which impacted on the design of the nursing education. In line with Elkins and Simeon (1979) and Laitin (1995) it is relevant to question the predictive power of regime based on Wildavsky's four predetermined regime and leadership types. Nurse leaders from Romania and Croatia moved from a hierarchical collectivism – characterised by Wildavsky as strong group strength and many prescriptions determining the individual space of action – towards competitive individualism (EU single market) characterised by weak stakeholder strength with few rules to take action. According to Wildavsky (1984c:5), group strength and the set of rules to take action have the largest payoff in predictive power for political processes, structures and outcomes. However, as expressed by different participants, the Romanian and Croatian nurse leaders moved from knowing their position within the collectivist hierarchy towards a European single market culture and reported that everyone found the move towards freedom difficult to manage. Most Romanian nurse leaders said that people found it hard to cope with "the new freedom" following the 1990 transition from a totalitarian regime to democracy. This is supported by the nurse/politician who emphasises that "we still need more time to change the mentality to change the model and to increase other freedoms next to the freedom to travel, the freedom to express ideas".

The findings equally evidence the challenge of linking, both theoretically and empirically, leadership behaviour with regime to explain the policy processes and outcomes (Karsten & Hendriks, 2011; Kane et al., 2009a; Kane & Patapan, 2008; Ruscio, 2008; Kellerman & Webster, 2001). Understanding the leadership-regime nexus necessitates the incorporation of the different facets of regime systems – e.g. totalitarian and liberal communism versus democracy – in relation to the economic-political Copenhagen criteria against which EU accession compliance is evaluated.

The EU accession and enlargement process implies merging different forms of regimes throughout Europe but not necessarily different styles of leadership. Consequently, the comparative findings suggest that a change of regime-specific contextual condition requires a form of nursing leadership that strengthens the advocacy of nursing stakeholders (strong group) within a multi-level governance policy process (low set of rules to take action).

In order for the nursing leadership to be successful in setting the agenda and influencing the policy process, the evidence shows that the nursing leadership constellations must entail simultaneous strengthening of different leadership positions (governmental chief nurse and those within nursing regulator, nursing union and professional association), allowing collective rather than dispersed nursing leadership. Thus, leadership becomes more a process whereby an individual nurse leader advocates and influences a group of policy-makers and politicians to achieve the common goal – compliance with Directive 2005/36/EC (Northouse, 2007:3).

Interestingly, Wildavsky's approach returns macro-politics – the EU *Acquis* – to leadership on the ground. He sees leadership as a consequence of regime (Wildavsky, 1987:166), so the themes emerging from the comparative empirical data (e.g. double identity; political elites and political party capacity; living through difficult conditions – Ceausescu regime and Balkan War; professional autonomy and advocacy capacity) strengthen the view that regime context is highly relevant to understanding the behaviour of individuals and, consequently, the roles of the individual nursing leaders and the achieved policy outcomes (Sabatier, 2006a). Although Kingdon multiple streams framework (Zahariadis, 1999; Kingdon, 1984) emphasises the actors' central role in the policy process, the three streams are insufficiently sensitive to contextual factors inherited from a pre-democratic regime.

Nevertheless, the findings not only confront the micro-nursing leadership with the nursing advocacy capacity needed to influence the macro-politics of EU accession but equally question nursing leadership within civil society. The findings indicate that the conventional view of democracy (i.e. diminishes the use of fear) cannot be taken for granted, given that the nursing leadership in Eastern Europe became familiar with 'a continuous fear' created by arms-length institutionalised forces. During the Communist regimes, participants learnt that the nature of the fear experienced could be transformed by publicising individual ideas and views in the media, using metaphorical language to prevent the secret police from identifying the source.

Advocating the upgrading of nursing education by going public (Croatian case) and writing a letter of complaint to the European Commission (Romania) must be evaluated against this continuous treat to advocacy. Thus, the findings support Singer and Wildavsky's (1993) argument that it is difficult to shake off fear generated by a totalitarian regime and war.

The identified contextual factors therefore add new knowledge to the way that the nursing education agenda was set prior to EU accession and how policies were processed within the existing Commission's mechanisms – TAIEX peer reviews and TAIEX capacity building. These help to explain the achieved outcomes in two former Communist-regime countries entering the EU. Based on these findings it can be argued that the EU accession process supports the establishment of a democratic regime and as such Europeanisation. However, findings also confirm indications in the political science literature that EU applicants have found democratisation less than easy to understand, let alone achieve (Hauss, 2003).

In both cases, findings confirm that EU enlargement and the EU accession process are instruments which facilitated the move from a totalitarian regime in Romania, and a civil and inter-state war in the former Yugoslavia, to peace in the Balkan region and democracy based on the rule of law. In both cases this aided development of the nursing profession within a set of regulatory rules and structures handling mutual recognition of professional qualifications, referring to professionalisation of the profession of nursing (Abbott, 1988a). This brings the discussion to the literature on Europeanisation, which Papadimitriou and Phinnemore (2004: 635) argue provides a "valuable resource in understanding the complex and unpredictable process of post-communist transition in central and eastern Europe". The findings indicate that the nursing leadership fits within this process although more efforts are needed to build policy capacity.

As it stands, Europeanisation theories and models are insufficiently robust to explain the different expectations of EU accession – whether from a purely legislative perspective, up to implementation, or into the development of a specific sector or profession. This depends on the definition of Europeanisation. Ladrech (1994, 69) says it is: "an incremental process of re-orienting the direction and shape of politics to the extent that EC political and economic dynamics become part of the organisational logic of national politics and policy-making". This emphasises the top-down approach of the EU accession process.

The findings indicate that the debate on downloading (national adaptation to EU policy), uploading (national projection into EU policy) and cross-loading (national interaction and learning within EU policy-making) in the Europeanisation literature (Delmartino & Dobre, 2008; Börzel & Risse, 2007; Hille & Knill, 2006; Pülzl & Treib, 2006; Treib, 2006; Schimmelfennig & Sedelmeier, 2005b; Börzel, 2005; Howell, 2004; Radaelli, 2004; Risse, 2004; Knill & Lehmkuhl, 2002) is less relevant for explaining EU accession as a policy window.

In contrast, Radaelli describes Europeanisation as: "a process involving, (a) construction, (b) diffusion, and (c) institutionalisation of formal and informal rules, procedures, policy paradigms, styles, 'ways of doing things' and shared beliefs and norms which are first defined and consolidated in the EU policy process and then incorporated in the logic of domestic (national and subnational) discourse, political structures and public choices" (Cini, 2007:407). This bottom-up approach occurs when MS begin to affect EU policy in a given area (only feasible post accession).

A country applying for EU membership does not have the political opportunity to upload any national legislation into the *Acquis* as applicants are not Council Members and have prior EU accession no voting rights within the EU institutions. Applicant countries (in this case Romania and Croatia) can start to upload their policy initiatives only on accession, when they become decision-makers in the EU policy-making process. The utility of uploading best practices in leadership and advocacy to change policies is important post EU accession as the European Parliament can draft own initiatives reports leading to Commission legislative initiatives. It is therefore argued that advocacy experience developed pre-EU accession, and the cross-loading policy initiatives of bilateral or eastern European agreements will help the nursing leadership to strengthen its position in the politics of policy-making at regional, national and European levels. Therefore, when explaining the impact of EU accession on domestic policy design and stakeholder engagement, there is a need to focus on the TAIEX mechanisms' impact on the Commission's comprehensive monitoring reports rather than further conceptualising downloading, uploading and cross-loading to explain the nursing leadership influence on legislative and professional development. Within this context, Kingdon multiple streams framework (Zahariadis, 1999; Kingdon, 1984) can be used to understand better the policy process as the problem, policy and political streams can help designing proposals to put forward for negotiations.

Following discussion of the pre-democratic contextual factors impacting on the policy process and outcomes, the chapter continues with a comparison of the take up of available Commission's mechanisms to reach compliance with Directive 2005/36/EC.

8.2 EU policy mechanisms

Comparison of Romania and Croatia shows that the TAIEX peer reviews were the key mechanism by which the nursing leadership influenced the process and advanced nursing education and the profession. As a Commission evaluation tool, the programme and the time-frame of the planned missions were well-prepared with the national experts, leading to comparable peer review outcomes.

My 2004 involvement in undertaking one Romanian peer review gave me better insight into how the mechanism is used to influence the policy process and better understanding of the way that different stakeholders (government, Commission, experts, nurse leaders, academics and clinical practice representatives) engage in the process. My insider-outsider position has been an advantage in understanding the Commission's mechanism as a tool to advance compliance with the *Acquis*. It has also helped me to understand the different views and experiences of the different stakeholders engaged (or not involved) in the processes. Based on the findings, it can be argued that the conflicting views and approaches to policy-making shown by the nursing leadership of the regulator and the professional association set the political agenda and determined the process and the achieved level of compliance.

Romania and Croatia show differences in agenda-setting. The Romanian nursing regulator is appointed as CNO in the Ministry of Health and therefore had more political power (than the RNA nursing leadership) to set 'his nursing views' on the governmental agenda. Furthermore, the Romanian nursing regulator and the professional association advocated conflicting approaches – the former adopted the nursing union's medical assistant approach to nursing; the latter advocated upgrading Romanian nursing education to higher-education level and using bridging courses to upgrade the entire Romanian nursing workforce to European standards. This was the course pursued by the Polish Nurses Association, supported by the Polish CNO.

Following EU accession, the Polish Government used €50 million of social cohesion funds to upgrade 25.000 nurses who had graduated prior to accession. In 2013, the Europe Parliament, Council and European Commission agreed during the negotiations of the Modernisation of the Directive 2005/36/EC (now called Directive 2013/55/EC) to allocate EU social cohesion funds to upgrade the Romanian nursing workforce. As such, it can be argued that there is some evidence of Romania benefitting from EU 10, especially from Poland: the Polish CNO shared her experience in designing the Romanian bridging courses through the Commission coordinators meeting on Mutual Recognition of Professional Qualifications.

In Croatia, the nursing regulator and professional association both advocated for upgrading nursing education but the chief nurse at the Ministry of Health, working together with the EU negotiator, blocked this agenda. This situation was different as only the government chief nurse advised the Secretary of State for Health; the nursing regulator and professional association were excluded from the design of the new Croatian Nursing Act during the negotiations of EU accession.

Remarkably, these three nursing leaders developed their professional careers through the CNA but now use their leadership positions and power to contradict each other when setting the professional agenda. These findings confirm the argument that the dynamics and the demand for leadership in shaping EU accession policies depend on the contemporary historical context of individual nurse leaders (Wildavsky, 1993). Although Porter-O'Grady (2003) definition of nursing leadership as a multifaceted process (e.g. identifying goals, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals), the empirical findings show that individual interest determines leadership. As such, the comparative study outcomes reflect Bonney (2003) findings that those interested in policy-making focus on those mechanisms designed for individuals rather than collective groups with the risk of preserving "the status quo rather than producing major change". Individual leadership differences can explain substantial variance in policy outcomes (House, 1997)

The case studies showed that the nursing leadership had broadly similar influences on the mechanisms to achieve compliance – the minister responsible for designing a new nursing law was advised by the governmental chief nurse concerning nursing education in compliance with Directive 2005/36/EC.

Complacency influenced both process and legislative outcomes. Consequently, as an EFN member, the CNA started pressuring the Government to negotiate with the Commission an alternative policy proposal (Kingdom, 1984). The Croatian nursing leadership used the TAIEX capacity building sessions to influence the process but, given that Croatian professional membership consists mainly of secondary-level nurses, was split in its perception of compliance.

In contrast to Croatia, the Romanian nursing regulator excluded the RNA from national government and European Commission negotiations. The EFN ensured that the RNA received all the information associated with EU accession and compliance. The EFN also supported increased advocacy from the RNA post EU accession.

Within the policy process, Chapter 3 of the *Acquis* (containing Directive 2005/36/EC) was closed before the weaknesses outlined in the TAIEX peer review reports had been addressed. The findings show that these weaknesses relate mainly to the design of a new nursing curriculum containing no general education topics (e.g. language, mathematics) and to reducing the medical orientation. Clinical placements and Article 31 setting out the role of nurses responsible for the planning, delivery and evaluation of nursing care also remain major challenges for achieving compliance with the Directive.

Nurses in Romania and Croatia are still called medical assistants and therefore face problems accessing free movement in the EU based on mutual recognition of professional qualifications. These challenges have remained untouched and unresolved as both national governments saw the *Acquis* as a potential exit route for nurses lured by better working conditions in other MS. Both governments agreed with the Commission that they would install a new nursing education curriculum at university level in compliance with Directive 2005/36/EC, from the date of entering the EU. This implies that the first nurses in compliance with the Directive graduated in Romania in 2011 and will do so in Croatia in 2017. Thus, the EU accession process ignored the issue of how to upgrade the entire nursing workforce. It can be argued that this represents a missed opportunity for a predominantly female profession to develop their skills and competencies and hence promote their ability to move within the EU on the basis of mutual recognition of professional qualifications.

Finally, the TAIEX peer reviews touched on the lines of accountability and responsibility between the nursing regulator, trade union, professional nursing organisation and the governmental chief nurse at the ministry of health. These remain unresolved, leading to confusion and conflicts between these four nursing leaders. It could be argued that it is the leadership task to resolve these conflicts and to clarify their roles in designing policies in compliance with Directive 2005/36/EC.

However, the findings suggest that the regime-specific contextual condition requires a form of nursing leadership that strengthens the alliance between state and non-state nursing stakeholders at different levels of government, leading to a policy outcome based on consensus. As such, the nursing leadership network constellations must entail the simultaneous strengthening of different nursing positions within the EU accession process. As argued above, leadership should become more a process in which individual nursing leadership positions become part of the advocacy to achieve a common goal for nurses and nursing (Northouse, 2007; Sabatier, 2006a).

When linking the three mechanisms to process new legislation, challenges identified in the TAIEX peer reviews were not carried forward and addressed or worked into any plan in the Commission's comprehensive monitoring reports. The Romanian TAIEX peer review recommendations of June 2004 identified significant gaps needing to be addressed by the stakeholders. Yet, all chapters of the *Acquis* (including Chapter 3 containing Directive 2005/36/EC) were closed two months after the Commission's comprehensive monitoring report of October 2004 was agreed by European political leaders.

The same occurred in Croatia – Chapter 3 was closed on 21 December 2009 and all chapters of the *Acquis* were provisionally closed in December 2010, despite the knowledge that a second peer review was needed to measure progress (June 2012). Although the case study findings show that the Commission’s mechanism (the comprehensive monitoring reports) failed to ensure that recommendations for compliance were carried through to alignment with legislative change, non-implementation of TAIEX recommendations is common when closing chapters of the *Acquis*. As such it can be concluded that the nursing example is just one of many non-implementation issues.

The two case study countries had different approaches to capacity building seminars. Romania did not apply for TAIEX capacity building seminars since government stakeholders saw no need to do so. Only in 2013, Romania was politically pushed to install bridging courses based on the positive experiences in Poland (25.000 nurses upgraded their qualifications).

In contrast, Croatia used the EU-funded capacity building seminars to petition for upgrading of nursing education demonstrating a different pathway and approach, taking up the advice and guidance of the Polish CNO. The CNA made full use of this mechanism to build alliances, formulate common agreed recommendations and enter into newly designed governmental structures dealing with mutual recognition of professional qualifications. It can be argued that Romania and Croatia had different nursing leadership capacity.

Furthermore, it can be argued that the EU accession process provided a policy window for the nursing leadership to become a stronger advocacy force and develop a coherent voice for nurses and nursing, helping to develop nurse leaders' skills and knowledge to lobby the Ministry of European Integration, Ministry of Health and Ministry of Education. By holding the Croatian government accountable for the final proposal negotiated with the Commission, the nursing leadership strengthened its position within Croatian governmental structures prior to EU accession.

Based on the evaluation of the use of Commission's mechanism to process compliance, the case study findings provide evidence that the Croatian nursing leadership was more politically oriented and adept at reaching out to 'opposition' nurse leaders. By strengthening its advocacy capacity, it was able to exert political pressure on the EU accession process.

Conversely, the Romanian nursing leadership only mobilised post EU accession. Interpretation of the comparative findings in the light of the literature shows that the EU accession process created a policy window for the nursing leadership to advance a professional agenda both before and after accession. Equally importantly, EU accession provided a mechanism for engagement in policy-making and thereby increased nurses' political knowledge, skills and advocacy capacity to steer ongoing development of the nursing profession in both of these eastern European countries.

Nevertheless, the professionalisation literature indicates that the creation of educational programmes and regulatory requirements is not the endpoint of the process of 'professionalisation' (Sanders & Harrison, 2008). Based on the findings considered here it can be argued that EU accession is not a professionalisation strategy. The aspirations of the nursing leaders relate to becoming a member of the EU but there is no indication from the findings that the nurse leaders had a professionalisation agenda in mind. EU accession is less about controlling the abstract knowledge on which their skills are based, and which compete for 'jurisdictions'. The jurisdictional claims in the legal system can be likened to compliance with EU accession negotiations, but the public and workplace aspects of profesionalisation are not adressed through the Acquis (Abott, 1988). Therefore, it can be argued that EU accession is a small step toward professionalisation, creating the conditions for developing a professional model but one which has yet to be defined by the profession itself in terms of a working model.

The comparative findings form part of the wider argument that nurses need to increase their engagement in multi-level governance and political decision-making processes at all levels of the policy system (West et al., 2011; Havens, 2009; Bruszt, 2008; Mason et al., 2002; Fagin, 2001; Cohen & Milone-Nuzzo, 2001; Gebbie et al., 2000; Wakefield & Kerfoot, 2000; Aiken et al., 2000; Cohen et al., 1996; Aiken, 1981). The study findings provide evidence that the lack of multi-level governance (Underdal, 2012, 2008) – as a system involving different institutions and stakeholders with diverging views and perceptions – impacts negatively on both the policy process and the outcomes achieved. It is argued that the Commission's comprehensive monitoring reports are not designed for multi-level governance and, consequently, are not sufficiently robust to respond to the challenges identified through the TAIEX peer reviews.

In contrast, the TAIEX peer reviews and the TAIEX capacity building seminars enable the implementation of systematic stakeholder engagement as the appointed experts can help to steer convergence of European and national state and non-state stakeholders. The Croatian case provides detailed empirical evidence on the importance of the positive impact that capacity building mechanisms exert on the multi-level engagement of state and non-state stakeholders. This is a critical component in influencing the policy process (Fagan, 2010; Klüver, 2009; Mahoney, 2008; Dür & de Bièvre, 2007a, b; Michalowitz, 2007).

The findings show that the TAIEX capacity building mechanism must be seen as a long-term investment to strengthen nursing leadership and its advocacy role; keeping compliance high on the political agenda regardless of the provisional closure of Chapter 3 or all *Acquis* chapters. By contrasting both cases, it becomes obvious that a stakeholder engagement approach needs to assume a more prominent place in the policy process (Mucciaroni, 1992).

Table 7: Stakeholder Mapping Romania

Stakeholder	Objectives	Interests	Influence	Potential
Government - Primary beneficiary and decision-maker **Chief Nursing Officer -** Romania CNO and President Chamber the same role – conflict of interest)	Stability of institutions guaranteeing democracy and the rule of law enforcement Strengthening judicial and administrative capacities and resources. Political and economic impact on EU decision-making processes	Creating new department in **Ministry of Education (**National Centre for Recognition and Equivalence of Diplomas) and **Ministry of Health** (Service for Recognition of Professional Qualifications and Continuous Training of Health Professions) Romania accedes to the EU in the same conditions as the ten States in 2004, with safeguard clause for nurses.	Government impact on Parliamentary process through Emergency Ordinances (excluding democratic debate) Conflict of Interest with CNO in Ministry of Health Incremental policy-making with little/no stakeholder consultation - even without consulting other ministries.	Increase standard of living for Romanian citizens, including nurses (average salary 250 euro) Joining the single market to boost economic competitiveness (difficulty to handle freedom) Access to EU funds – neglected for upgrading nursing education Corruption and organised crime - still less freedom of expression
European Commission – Directory General Enlargement **TAIEX Peer Review Experts** – selected from National EU governments and NGOs	Aiming at stable political and economic Balkan region Shifting all economic, public and social sectors towards EU-standards (Acquis) Free movement of people and workers based on mutual recognition of professional qualifications (top priority of Single Market Act)	Strengthening judicial and administrative capacities and resources (Social Cohesion Funds) Boost Single Market with freedom of movement of persons, services, goods and capital Compliance with the Minimum Requirements as set out in Directive 2005/36/EC	Bilateral negotiations and monitoring progress based on the system of conditionality Monitoring reports and 'safeguard clauses' Recommendation TAIEX experts taken up in the Commission Monitoring reports	Strengthen regulatory infrastructure (€ 242 million/yearly) TAIEX recommendations not taken up for action to build administrative and professional capacity
Nursing Regulator – arm length of the Ministry of Health	No radical change to the health system - Keeping the nurses in Romania Keeping "status quo" and calling nurses "medical assistants"	Political power, convening power, and lobbying in Ministries. Regulation of the profession – fees for each nurse	Conflict of Interest – President also CNO in Ministry of Health Support from those physicians in politics which see nurses as their assistant.	Most effective impact on legislative development prior and after EU accession Use Enlargement Funds to upgrade nursing (a missed opportunity)

Stakeholder	Objectives	Interests	Influence	Potential
Nursing Union – Social Dialogue	Improve the working environment and conditions Increase the salary of nurses so they do not lead Romania for employment in other MS	Keeping nurses education at the lowest level and defend the workers position instead of a health professional perspective	Alliances with Nursing Regulator	Invisible impact on EU accession Use Enlargement Funds to upgrade nursing (a missed opportunity)
Professional Nurses Association – Small community based on voluntary work – connected with EFN and ICN	Upgrading nursing education and making sure nurses contribute to research in nursing Improve the working environment and conditions	Upgrading nursing education and develop standards of care linked to quality of care and patient safety	No organised influence Personal contacts within the Ministries European and International representation (EFN and ICN)	Informal and weak impact on EU accession Complaint submitted to the European Commission - advocacy

Table 8: Stakeholder Mapping Croatia

Stakeholder	Objectives	Interests	Influence	Potential
Government - Primary beneficiary and decision-maker **Chief Nursing Officer – Croatian** CNO being President Chamber – conflict of interest)	Stability of institutions guaranteeing democracy and the rule of law enforcement Strengthening judicial and administrative capacities and resources Political and economic impact on EU decision-making processes	Government allocates credentialing with the Nursing Chamber, no departments in the Ministry of education or the Ministry of health Croatia accedes to the EU in the same conditions as the ten States in 2004, without safeguard clauses	Government dialog with Parliamentary process - Impact Balkan War -United Nations' war crimes court The Hague	Increase standard of living for Croatian citizens Joining the single market to boost economic competitiveness Access to EU funds – but neglected for upgrading nursing education – taken up for capacity building Corruption and organised crime

Stakeholder	Objectives	Interests	Influence	Potential
European Commission – Directory General Enlargement **TAIEX Peer Review Experts** – selected from National EU governments and NGOs	Stable political and economic Balkan region Shifting all economic, public and social sectors towards EU-standards Free movement of people and workers based on mutual recognition of professional qualifications	Strengthening judicial and administrative capacities and resources Boost Single Market with freedom of movement of persons, services, goods and capital Compliance with the Minimum Requirements as set out in Directive 36	Bilateral negotiations and monitoring progress based on the system of conditionality Monitoring reports and 'safeguard clauses' Recommendation TAIEX experts taken up in the Commission Monitoring reports	Strengthen regulatory infrastructure TAIEX recommendations not taken up for action to build administrative and professional capacity
Nursing Regulator – organisation set up by nursing act and accountable to Croatian Ministry of Health	No radical change to the health system - Keeping the nurses in Croatia	Political power, convening power, and lobbying in Ministries. Regulation of the profession – fees for each nurse	Regulation Nursing care Mandatory membership	Most effective impact on legislative development prior and after EU accession Use Enlargement Funds to upgrade nursing (a missed opportunity)
Nursing Union – Social Dialogue	Improve the working environment and conditions Increase the salary of nurses so they do not lead Croatia for employment in other MS	Keeping nurses education at the lowest level and defend the workers position instead of a health professional perspective	Alliances with Nursing Association	Invisible impact on EU accession Use Enlargement Funds to upgrade nursing (a missed opportunity)
Professional Nurses Association – Small community based on voluntary work – connected with EFN and ICN Nursing Union and Nursing Regulator developed out of the NNA	Upgrading nursing education and making sure nurses contribute to research in nursing Improve the working environment and conditions	Upgrading nursing education and develop standards of care linked to quality of care and patient safety	No organised influence Personal contacts within the Ministries European and International representation (EFN and ICN)	Informal impact on EU accession

Non-state stakeholders have to demonstrate their importance in order to be heard in the EU accession policy process (Young et al., 2010; McCown, 2009: Friedrich, 2006). The Commission's restrictive rules concerning their engagement in this process need to be reviewed if successful policy outcomes are to be guaranteed (Scharpf, 1997). The Romanian study findings show that, without the engagement of non-state stakeholders, the policy process risks being dominated by governments' views with a clear drive to preserve the status quo rather than facilitate change (Bonney, 2003). Within this context it is important to mention that it is mainly DG Enlargement and DG Internal Market control the compliance with the Acquis for Directive 2005/36/EC while the health directorate, DG Sanco, is not a key player in negotiations. Although DG Sanco has mobility of health professionals (Joint Action EU Workforce for Health) and quality and safety (Joint Action Quality and Safety) as part of their policy remit, DG Sanco and DG Internal Market have competing interests: liberalisation versus solidarity/universal access of the healthcare sector. However, policy processes and decisions cannot remain the prerogative of Commission and government civil servants (mainly physicians and lawyers), ignoring policy input from the nursing leadership. Stakeholder and citizens engagement is key to design policies fit for practice (World Bank, 2013).

Some of the literature considers whether EU accession is purely about the net national interest – for example, the research of Schimmelfennig and Sedelmeier (2005b) and Moravcsik and Vachudova (2004). Certainly, the compliance process for Directive 2005/36/EC did allocate EU accession budgets to build policy and administrative capacity to design, consult and implement the Romanian and Croatian nursing acts. Also, the TAIEX budget did pay for capacity building seminars (as discussed below). But €15 000 is a miniscule proportion of the €20 billion EU accession budget. In both countries, most of the money was allocated to tourism; public finance (e.g. public procurement); fighting organised crime, drugs trafficking and abuse; policing; judicial reform; and public administration (Dragan, 2007; World Bank, 2005, 2004; European Institute of Romania, 2006a, 2004; Porter, 2003).

The Croatian nursing leadership prepared a financial case to invest in nursing education. This process was managed in such a way that the European Commission granted financial support for three capacity building sessions in which state and non-state stakeholders were invited to discuss nursing education in Croatia.

It can therefore be argued that financial streams for EU accession helped to strengthen the nursing leadership and management of the seminars as the resulting consensuses on what should be done prior to EU accession reached political decision-makers at national and European levels.

As Secretary General of EFN I was one of the speakers at the 2008 and 2009 seminars on EU accession, explaining compliance with the minimum requirements in order to assist the nursing leadership to reach consensus. This new type of exercise boosted the nursing leadership self-esteem and motivation through sharing expertise with other Balkan national nursing associations learning from the Croatian case.

It is important to note the financial opportunities provided by the EU accession process as these are an important incentive for engaging with accession. The data on their usage indicate that nurses and nursing are not a political priority for the Romanian and Croatian governments. Other health professionals (e.g. physicians, pharmacists, dentists) have not benefited from European TAIEX funds, despite facing some major challenges in upgrading their curricula towards European standards, as indicated in the Commission's comprehensive monitoring report for Croatia. Only the nursing leadership took up the challenge to organise TAIEX seminars as they were well informed through their pan European organisation that these possibilities for funding existed. Although it can be argued that the failure to use any of the pre-accession funds to upgrade nursing education in Romania and Croatia has been driven by complacency, the absence of a professional EU accession strategy and the lack of a nursing voice in the European Commission can be identified as weaknesses to apply systematically for EU accession funds. Nevertheless, as long as governments perceive scaling-up of nursing education equals losing their nursing workforce to other Member States within the EU, pre-accession technical assistance funds will not be allocated to the health sector.

With respect to economic and social cohesion, TAIEX provided assistance for the implementation of national and regional policies in human resources and social services, education, local and regional infrastructures, environmental protection at regional level and development of small and medium enterprises. It can therefore be argued that neither government recognise the opportunity for pre-accession funds to be invested in nursing. Government approval was required for the

application of EU capacity-building funds so non-state stakeholders willing to organise capacity building sessions were in a weak position to challenge the prevailing government views.

8.3 Legislative and professional outcomes

The comparative case study findings related to the context of policy-making and the mechanisms to process compliance enable comparison of the legislative and professional outcomes of the EU accession process in each applicant country.

Notwithstanding the major differences between the Romanian and Croatian pre-democratic regimes, the findings indicate that nurses had to overcome quite similar obstacles in terms of curriculum content (transform vocational training into higher/university education for nurses); policy and clinical decision-making, which were medically dominated; and the inherited Semashko working conditions which put pressure on the retention of nurses. Romania and Croatia also show quite similar legislative outcomes. It can therefore be argued that their governments used the policy window provided by EU accession to achieve new curricula for nursing at higher/university level although, from a professional perspective, compliance was far from complete.

The Romanian and Croatian nursing acts' compliance with Directive 2005/36/EC can be assessed by analysing the nursing education framework in relation to the four minimum requirements as set out in the Directive:

1. a minimum entry level of 10 years of general education;
2. a full educational programme of 4600 hours and a minimum of 3 years;
3. a 4600-hour programme of which one third must be theoretical and at least one half must be clinical training on a full-time basis; and
4. a curriculum that includes at least the programme as described in Directive Annex V.

Compliance with the first requirement was achieved as the new nursing education programmes start after 10 years of general education, which was not the case during Communism. Prior to EU accession, individuals in both countries entered nursing at 14 years old and therefore a major change was required to comply with this requirement.

Both the Romanian and the Croatian authorities made significant efforts to change their curricula in compliance with the second minimum requirement (4600 hour programme as set out in Article 31). At the time of the study, Art 31 did not include a competency based approach, which was only introduced in 2013 with the modernisation of the Directive (Directive 2013/55/EC). Nevertheless, the hours of study stay a pre-requisite but can in the new Directive be expressed in ECTS to fit other European developments (Bologna).

Fulfilment of the third requirement (ratio between theory and practice) remains unclear as nurse training is combined within a general education programme. Furthermore, even the newly developed higher-level education shows limitations in the content of the theoretical part of the curricula. Clinical supervision takes place in primary, secondary and tertiary health-care facilities, supervised by experienced nurses and by mentors who are nurse graduates prepared by twinning programmes. It is only in 2014 that Romania started, under political pressure of the Commission and European Parliament, with teaching the teachers (in nursing).

However, there is still some non-compliance with the fourth minimum requirement (Annexe V in which study topics are listed) as authorities are resisting changing the title from Medical Assistant for General Care to Nurse in General Care.

It appears that both Romanian and Croatian governments wish to keep nurses as physicians' assistants. As set out in the findings chapters, the 'sanitary' vision and the nurse's role as assistant to medical professionals has not been abandoned. It can therefore be argued that the reforms being implemented by the two governments focused only on the duration of training, not on the content nor the educational methodologies required for effective delivery of a modernised nursing curriculum. The reform fails to shift nurse education into settings where the science and art of nursing can be taught in a multi-disciplinary setting, with a curriculum containing a research component, in order to generate graduates who are evidence-based in their practice and equipped to undertake lifelong learning. This equally indicates the failure to professionalise nursing in Romania and Croatia (Sanders & Harrison, 2008). Changing the scope of practice and professional boundaries as they existed during Communism was a challenge although legislatively progress has been made to employ Taiex to advance nursing. As such, it can be argued that Taiex helped to redraw the jurisdictional boundaries between medicine and nursing,

although the public and workplace components of professionalisation are not within the scope of the Acquis compliance process (Abbott, 1988).

As set out in the respective nursing acts, the nursing education curricula refer only to the first generation of nurses graduating with a new programme after EU accession – from 2011 for Romania and 2017 for Croatia. Consequently, all nurses trained in Romania and Croatia prior to EU accession do not comply with Directive 2005/36/EC. Should they want to move to another EU country, these nurses must apply for compensation measures under which applicants are evaluated on a case-by-case basis by the nursing regulator or competent authority in the host MS (criteria in Directive 2005/36/EC; in Directive 2013/55/EC it is the home MS). The nursing curriculum of the applicant is evaluated by comparison with Annexe V of Directive 2005/36/EC in order to identify gaps/courses missed within an applicant's nursing education. The regulator requires completion of any extra courses required before a nurse is registered to practice. Nurses from a 'pre-accession and communist regime' who do not meet these requirements may work in other MS, but only as care assistants. Hence, it can be argued that the EU accession policy process did not create enough opportunities for Romania and Croatia to upgrade their entire nursing workforces from secondary level to degree level.

It can be argued that the free movement of nurses and physicians within the Single Market Act should feature more prominently on the European enlargement and accession research agenda. A single economic market works best when its workers are mobile (Buttonwood, 2013). Patrick Basham statement in "Balkan Migration, the EU and Liberal Solutions emphases that 'the political and economic downsides of migration are not labour mobility's Achilles' heel; rather, they are a testament to the inability of the governments of numerous EU MS to synchronise their respective economic policies with EU immigration policy" (2013). Nurses and physicians moving within the system of mutual recognition of professional qualifications do so to find a better job, better working conditions and better salaries. The mutual recognition system becomes a safeguard against 'alternative jobs' with less pay and status. Nevertheless, Wistow et al. argue in the Prometheus study that the scale of migration was exaggerated in the minds of policy-makers and that the migratory flows never reached the levels anticipated in the early days of EU accession (Prometheus, 2012). Therefore, Europeanisation needs to address the consequences of non-compliance for an entire health workforce. EU citizens cannot be guaranteed equal opportunities

if EU accession targets only a very small segment of the future nursing workforce rather than upgrading the entire nursing workforce to European standards.

In Romania, 200 000 of a total of 250 000 nurses graduated prior to EU accession. In Croatia, 6% of the 34 000 nurses educated under the old Communist regime are in compliance with Directive 2005/36/EC. It will take several years before the entire Romanian and Croatian nursing workforces achieve European standards as no development milestones have been set to manage the entire workforce transition. It is regrettable that these two governments have not instituted prior EU accession bridging courses for this transition.

The creation of institutional frameworks for mutual recognition procedures forms part of the achieved legislative outcomes impacting on the process to obtain the necessary justifications for mutual recognition of professional qualifications. In addition to the existing National Centre for Recognition and Equivalence of Diplomas (1999), Romania created a new Council for Occupational Standards and Attestation (COSA), an autonomous body to ensure transparency in vocational qualifications. These operate alongside the National Centre for Recognition and Equivalence of Diplomas (NCRED) within the Ministry of Education and the Service for Recognition of Professional Qualifications and Continuous Training of Health Professions within the Ministry of Health that were established during EU accession. State stakeholders (health and education ministries) show some rivalry over the credentialing territory for regulating mutual recognition of professional qualifications.

This is a result of the EU accession process in which lack of good governance has increased the complexity, and reduced accessibility and transparency, concerning individual nurses' applications for mutual recognition. As such, it can be argued that confusing and complicating processes for credentialing deliberated to stop migration. Although the true scale of the migration process is perceived less important as expected (Prometheus, 2012), emigration can lead to falling population in Eastern European countries and demographic manpower, and brain-drain causing unsustainable economies, the system of mutual recognition cannot be misused to prevent citizens, women, nurses, to freely move within the EU based on the mutual recognition of their professional qualifications.

For example, a Romanian nurse wanting to work in another EU MS faces major administrative challenges from a mutual recognition process which is divided between several governmental institutions dealing with credentialing. The Romanian nursing association warned against these barriers but the rivalry between ministries appears to have had greater priority and impact on the EU accession process.

The Croatian accreditation process is also allocated to different agencies – the Government Agency for Professional Vocation, the Sectoral Council for Health and Social Welfare and the Centre for Promotion of European Standards in Health. This can be confusing and time consuming for individual nurses seeking mutual recognition in order to move to another MS. Therefore, it can be argued that failure to upgrade the nursing workforce and the resulting rivalry between different mutual recognition agencies ensures that Romanian and Croatian nurses move under the general system instead of benefitting from mutual recognition of professional qualifications. These views were articulated by many interviewees arguing that nobody can stop medical assistants leaving the country. This argument is equally supported by data from the UK regulator (NMC) showing more Romanian nurses' move within the general system instead of the sectoral system (MRPQ).

The creation of new institutional frameworks also relates to the development of a new ministerial position of governmental chief nurse within the ministry of health and the establishment of a nursing chamber under the terms of a nursing act. Still, the lines of accountability and responsibility between the trade unions, professional nursing organisations and ministries of health remain vague. In Romania this creates a conflict of interest – no other EU MS allows one person to be both governmental CNO and head of the nursing regulator; separation of these powers is deemed important in most jurisdictions (Keighly, 2009). From the Croatian case it can be argued that setting up of the regulatory system for nurses within the EU accession process helped to design the post of governmental CNO.

Within such a short period of Chapter 3 negotiations, these posts and structures could not have been developed unless EU accession was a policy window. Many participants (policy-makers and politicians) argued that governmental policy processes underpinning the healthcare system should include nurses. Yet, the findings do not indicate that the nursing leadership provided a

powerful united voice in setting the agenda, influencing the process and developing the profession.

In both cases, the key issue for professional outcomes concerned the conflicts between the four nursing leaders – nursing regulator, nursing union representative, professional nursing leader and governmental CNO. Failure to operate within a joint professional and political agenda was due to different institutional power structures, self-interest and purely personal conflicts between the nursing leaders, in both Romania and Croatia. Such rivalry makes it challenging to engage in the policy-making process, at national and European level. This confirms House's (1997) argument that current leadership theories and models give too much emphasis to the individual while the search for common values, goals and views between the key political nursing leaders – the chief nursing officer at the Ministry of Health, the nursing regulator leader, the nursing professional association president and the head of the nursing union – inhibits having a common agenda and common views towards the policy-makers designing new policies in compliance with EU legislation. As such it can be argued that the lack of collective leadership, the lack of a united voice for nurses and nursing, impacted negatively on the compliance with the Directive 2005/36/EC (Maxwell, 2007).

In both these post-Communist cases, the nursing constituencies have developed differently and in ways that affect process and outcomes negatively. In Croatia, responsibility for all aspects of EU nursing negotiations is highly concentrated in the Ministry of Health, staffed by civil servants who began their careers in the CNA. In contrast to Romania, all current Croatian nurse leaders from the different constituencies have worked in this professional association – both the Nursing Council and the Nursing Union were established following internal personal conflicts between CNA members and leaders. Over time, CNA and Nursing Union nurse leaders restored their alliances in order to have more impact on joint working and setting the national nursing agenda for harmonisation of education, working conditions and salary negotiations. President of the CNA until 2003, the current president of the Croatian Nursing Council created the organisation under the National Nursing Act, acting on an opportunity created by the Balkan War.

Since the establishment of the Nursing Council in 2004 – rather than targeting the nursing topics that need to be raised with policy-makers and politicians and developing legislative proposals for

government prior to accession – the nursing constituencies have shown more concern about which of them bears responsibility for raising any issues.

In Romania, the Nursing Act sets the terms of reference of the regulatory body for nursing. Any initiative from the professional association which crosses the boundaries of these terms of reference is blocked as neither nurse leader of these organisations is prepared to communicate to reach consensus. European Directive requirements are the main priorities for both nursing communities but continuous professional development is the next battle, despite unfinished business concerning pre-registration. In both Romania and Croatia, the power game between the regulator and the professional association is the main barrier to setting a common national professional nursing agenda and consequently influence the international and European constituencies. In both countries, the national nursing act recognises the Nursing Council as official partner in governmental negotiations – the CNA is perceived to have more influence in setting the agenda as the Romanian Council stops the RNA from setting a legislative and professional agenda prior to EU accession in Romania. These divisions between the nursing constituencies bring power battles into the European and international arenas; nurses are left behind in this battlefield. Policy outcomes could be explained by Kingdon multiple streams framework (Zahariadis, 1999; Kingdon, 1984) emphasising the actors' central role in the policy process with the third stream focussing in alliance building and political elites.

In addition, medical domination compounds the challenge driven by the power game dynamics of the policy process. The medical domination that existed prior to accession continues, but each country has developed different pathways to achieve greater professional autonomy and become independent of physicians. Changes to the culture of medical domination require health system reform in terms of political engagement. The search to establish a separate identity is key for achieving the requirements of the Nursing Directive.

In both Romania and Croatia, competing nursing leaders from the regulatory, governmental and professional bodies set the agenda. In turn, the effectiveness of their networking determined the degree of support from other national and international agencies. Nurse leaders from the different policy communities have no common professional ground for setting the nursing agenda prior to EU accession. Consequently, all face challenging issues – most notably, mutual recognition within the EU and the nursing shortages caused by brain drain (Prometheus, 2011).

Romanian nurse leaders are still struggling with the post-Ceausescu regime but Croatian nurse leaders have been more proactive in setting the nursing agenda. For example, the TAIEX capacity building seminars led to the nursing leadership engagement in institutional policy processes dealing with the acquired rights of individuals within the EU free market.

Furthermore, the leadership capacity to influence policies is dependent on a strengthened evidence base and the credibility of the nursing leadership. Nurse leaders also need to speak with a united voice for nurses while communicating with the public about what nursing is about, who nurses are and what added value they bring to Romanian and Croatian society. In Croatia, the findings indicate that the EU accession period helped to develop the leadership and advocacy capacity of the nurse leaders. In turn, their greater self-confidence drove them to organise regular press conferences and take up leadership positions at European level.

In contrast, the Romanian nursing leadership appears to be impeded from assuming authority and making changes by the continuing perception that this is the sole responsibility of the government. So, everybody is waiting for someone else to change something. Nevertheless, findings also indicate that nurse leaders realise that it is important to 'have the political wind on your back', while 'knowing the political actors' helps to shape strategic engagement in the policy process. The nursing leadership can draw strength as the focus is targeted on 'concrete advocacy actions' with the ambition to 'think politically' and even 'becoming politicians themselves' to make things happen in the long-term.

Based on the comparative findings, it can be argued that the EU accession process enabled the nursing leadership in Romania and Croatia to think more long-term, acknowledging that EU accession is just the first milestone in a process of professionalisation. The advocacy literature describes the theory of change process (Reisman, 2007), explaining why certain advocacy actions lead to the desired change. In order to influence policy successfully, nursing leader advocates need a deep and sophisticated understanding of the EU policy context; the mechanisms available to process compliance; and the political landscape in which their national government operates in order to build alliances and influence politicians and policy-makers designing new legislation. As such, it can be argued that nurses' advocacy and leadership are key components for developing nursing as a profession but acknowledging professionalisation goes way beyond legislative and regulatory frameworks leading to closure of occupations. Finding

show that inter-professional competition (doctors dominating nurses) becomes overt when legislative developments in Romania and Croatia lead to more autonomy of the nurses in clinical practice (Hartley, 2002).

However, the findings indicate that nursing leaders advocating change searched for mechanisms by which nurses can influence decision-makers and become part of the process and solution to health-care challenges. These mechanisms relate mainly to building advocacy capacity within their own constituency in an attempt to lead with a clear vision and to make their members and the public aware of the implications of failure to comply with the Directive. Furthermore, from an advocacy perspective, empowerment concerns challenging and transforming inequitable power relations. These caused high degrees of tension, struggle and controversy throughout the EU accession process.

Although the literature identifies empowerment as a key indicator of the success of advocacy, the findings show that the absence of transforming power relations was the main barrier for achieving sustainable gains. Therefore, advocacy had only limited success as leadership is context-based and needs to take into account of the power asymmetry between state and non-state nursing stakeholders. The advocacy capacity of the nursing leadership in the Romanian and Croatian case studies relate to: (i) mobilising public support (in Croatia); (ii) building a coalition with civil society; (iii) policy engagement; (iv) policy impact; (v) empowerment in closed political systems; and (vi) voting power. The latter category does not appear to have been articulated in the international development literature (Coffman, 2009; Reisman et al., 2007).

Hence, the different dimensions of successful outcomes can be interpreted from: (i) policy success; (ii) strengthening civil society capacity for advocacy; (iii) enlarging democratic space; and (iv) supporting people-centred policy-making (Guthrie et al., 2006; Chapman & Wameyo, 2001).

Finally, when exploring the impact of the nursing leadership on influencing policy outcomes, it could be argued that Kingdon multiple streams framework (Zahariadis, 1999; Kingdon, 1984), emphasising actors' central role in the process of transforming information into policy outcomes, could be considered to explore context of leadership, the leadership capacity to influence the policy process and the impact of nursing leadership on the policy outcomes. The lack of a united voice of the nursing stakeholders and some nurse leaders being excluded from the policy stream

due to the nursing community – the nursing regulator, the chief nursing officer, the nursing union and the professional nurses association – having no agreed common ground for policy alternatives prior entering the EU negotiations. Although the political climate in Romania and Croatia did not take the upgrading of the nursing education towards EU standards serious, the nursing community united voice could have countered the political climate by advocating together policy change. Due to the political stream being un-organised with no common policy alternatives put the political forces of the nursing community in a weak position negotiating EU accession (Kingdon, 1995). Although EU accession is not the endpoint but rather the starting point for developing nursing and its leadership, the conflicting positions on professional and legislative themes continue to exist post EU accession unless all Romanian and Croatian nurse leaders engage in multi-level governance to understand the problem, to process alternatives and to jointly influence politicians to achieve compliance (Underdal, 2012; Bruszt, 2008). Creating a united voice capturing the diverging views of the nurse leaders on compliance with the Acquis, in particular the Directive 2005/36/EC, next to focussing on a common agenda to influence policy-makers and politicians negotiating EU accession, the nursing professionalisation will be challenged within and beyond national borders. Therefore, it can be argued that the study findings indicate the need to develop an EU accession strategy focusing on the nurse leaders' capacity to influence the transformation of the *Acquis* into National legislation. The successful legislative and professional outcome depends on an effective nursing leadership deploying the policy window of the EU accession and demonstrating that the previously unthinkable has become acceptable within Europeanisation (Klein & Marmor, 2004).

8.4 Reflexivity

While context-independent predictions and universal generalisations were not within the aims of the research study, every effort was made to uphold methodological rigour and contain potential bias. In this context, my positionality became vital throughout the design of the study, forcing me to acknowledge my own power, privilege, and preconceptions particularly regarding Eastern European countries joining the EU. It can even be argued that my professional status made the research a political and personal process for change, although such a claim is perhaps way too ambitious.

To establish the concrete, practical and context-dependent knowledge the research aspired to gain, I introduced a 'safeguard clause in the research process' by consciously and systematically turning back on myself, examining my own intentions, my choice of methods and examining the possible effects of my position as Secretary General of EFN on the collection and interpretation of the qualitative data. I am therefore accountable for my own research decisions, my authority, and my moral responsibility relative to answering the research question: "*To what extent did the EU accession process provide an opportunity for the nursing leadership in Romania and Croatia to advance a professional agenda at national level?*"

In the following paragraphs I discuss the limitations of the research design, next to the method opted for the data collection and analysis strategy employed in order to enable the formulation of empirically driven recommendations. In so doing I lay my research process bare for the reader to see.

8.4.1 Study design

As an insider into the accession process of the two case studies, Romania and Croatia, I was consciously aware of their different starting points for entering the EU: Romania joined the EU on January 2007 while Croatia joined in July 2013. The different timelines of EU accession unavoidably impacted on the design of the research and especially the conduct of the interviews. The interview schedule in particular was in a process of refinement throughout the research as I applied the knowledge gained out of the Romanian case and adjusted the interview schedule for Croatia (Appendix 5 and 6). As the research findings depend on what I asked in the interviews - and at the same time what I did not asked - the interview schedule was a guide for me to ensure similar topics were covered across the interviews and so enable a sense of consistency in the data. The interview guide was particularly helpful in fine-tuning my own interviewing capabilities and skills, especially when political elites tried to avoid some questions, and particularly those referring to the Communist regime, political leadership and political party capacity; an issue widely reported in the research literature (Ward & Jones, 1999; Werning et al., 2002).

The development of the interview guide for the first interviews in Romania (2005–2006) required decisions to be taken on the topics to be covered while having little insight on how well these would be received by participants. Here, my insider status and familiarity with the related policy literature acted as a sensitising mechanism to the delicate political topics required addressing. As

an insider into the accession process of the two case studies, Romania and Croatia, I was consciously aware of their different starting points for entering the EU: Romania joined the EU on January 2007 while Croatia joined in July 2013. The different timelines of EU accession unavoidably impacted on the design of the research and especially the conduct of the interviews. The interview schedule in particular was in a process of refinement throughout the research as the development of a semi-structured interview guide for the second case, Croatia (2007–2008), I applied the knowledge gained from the first set of interviews to enable to design the interview guide for Croatia.

The design of both interviews guides took considerable time recognising the nature of the iterative process. The interview guide was particularly helpful in fine-tuning my own interviewing capabilities and skills, as political elites, politicians and policy-makers tried avoiding those questions referring to Communism while trying taking over the interview to pass on their political messages towards my position as Secretary General of the EFN (Ward & Jones, 1999; Werning et al., 2002).

Concerning the conduct of the interviews in Romania and Croatia, I identify and openly acknowledge both ethical and methodological issues arising due to my positionality; I cluster these as issues of sampling, accessibility, language and confidentiality.

Firstly, as regard sampling, I relied out of necessity to a snowballing technique in order to gain access to hand to reach political elites. To ensure a balanced perspective, I succeeded in securing a final sample that provided a good spread of informants coming from both the nursing leadership and policy environment. However, the fact that the inclusion of participants to the research depended on input received from other participants is inescapable. Snowballing was indeed a useful and appropriate technique to employ in order to meet the requirements of the research, but the likelihood of biased suggestions for inclusion is acknowledged since these may have been dependent on the message key elites wanted to pass on through my study.

Accessibility is a second key concern. Inequality of power between interviewer and interviewees may have been an issue since the presence of the researcher – being the lobbyist for the nurses towards the European institutions – may well have influenced the responses and behaviour of participants to some degree, as Kozinets (2002) also identifies. Although access to nursing leaders, policy-makers and political elites was very easy, likely facilitated by my position as

Secretary General of EFN, and most participants gave the impression of being honoured to be selected for interview, some participants had a very clear political message to tell me. My own elite policy position in the EU impacted on the interview as the participants took their opportunity to share their political messages with me, often deviating from the interview schedule. These messages related mainly to the political imperfections, the regulation of the nursing profession and the Balkan war (for Croatia).

It can be argued that political elites attempted to use this research study, and the researcher, as a vehicle to articulate, strategise and advance their own ideas and political agenda. Although most political elites were very influential, prominent and well-informed people, they regarded my position as Secretary General of EFN very influential in Brussels and hoped their ideas and concerns would be picked up in the EU policy arena; as some confided to me retrospectively.

The language barrier between the researcher and the researched is another key issue acknowledged to have influenced the design of the study. The language used during the interviews was mainly English as most participants were adept at speaking English. In some interviews, however, a translator was required since participants did not want language to be a barrier in sharing their views and ideas. On these occasions the translator also translated the interview transcripts. As language is not a neutral medium, the translations (of interviews and transcripts) of some interviews from Croatian and Romanian into English may have influenced the findings. As a non-native English speaker myself, the interaction between languages, English-Romanian, English-Croatian, French-Romanian and English-English as second or even third language was a key challenge when collecting, analysing and interpreting data. To offset this challenge I took care in investing extra time in carefully both listening and reading back the interviews to become intimately familiar with my data and ensure my findings were as an accurate representation of my participants' views as possible.

A final key concern was confidentiality. The anonymity of the participants recruited for interviews was vitally important since participants within and between the cases may have been able to trace each other. Some participants could have perceived the study as a potential threat to their job and public image, especially since some held unique and powerful positions.

Although all participants are confronted with the politics of policy-making, their position could be at stake if their privacy was not adequately guaranteed, especially with the presence of an interpreter/translator. Therefore, extra care was taken both during the analysis and reporting of findings to anonymise the text and protect the identity of my interviewees.

8.4.2 Research Method

Next to the reflections on the research design, the research method opted for needs to be acknowledged for its limitations. The choice for a comparative case study following an ethnographic approach was underpinned by the nature of the research question, aim and objectives, the exploration of underlying meanings, the importance of reflexivity and the capacity for new knowledge development; as discussed in Chapter 5. Although some researchers may argue that research is a-political, I contend that research becomes political when it recognises the narratives.

Revealing the texture of policy settings, especially within the context of Communism and the Balkan war, is challenging when the researcher never experienced poverty or surviving a totalitarian regime. Questioning generalisations on regime context and subverting the process of othering (Abu-Lughod, 1993) is difficult to formulate in words, especially when English is not the native language of the researcher and participants. The decision for a specific research method – a comparative case study following an ethnographic approach – was therefore not so obvious to make.

Patterns of participants' shared and contrasting meanings and perceptions across cases are not easily quantifiable (Fraenkel & Wallen, 2006) and can be achieved only by developing over time an intimate familiarity with the dilemmas, frustrations, routines, relationships and risks that form part of the participants' everyday lives (Grills, 1998b). Given the complexities and sensitivities of the research topic it was important to choose an approach that privileged my participants' views while remaining flexible enough to adapt to the challenges and opportunities of the political scene. The insight gained to such a challenging topic indicates that the choice of research method for the study was indeed appropriate.

8.4.3 Data collection and analysis

Concerning data collection and analysis, I acknowledge that a comparison of two small-scale cases, based on fifty interviews cannot provide a solid basis for predictions or generalisations. Therefore, I acknowledge that it is difficult to build theories on the basis of comparative case studies (Dul & Hak, 2008; Morgan, 2007; Elgie, 2003; Valenzuela, 1998) and recognise that the findings should be interpreted with caution.

Throughout the process of data analysis it was important I remained disciplined in suppressing my subjectivity by, for example, continuously questioning myself on why I took a particular option instead of choosing another. This proved useful in fully understanding my own biases and prejudices linked to nurses, nursing, leadership, policy-making and EU accession.

Finally, the main challenge was building an empirical theory, and to search for a reasonable degree of confidence for this knowledge in the field of EU accession and enlargement. Although it may have been more straightforward to choose a model, such as Kingdon's (1984) policy streams, and try to fit the findings into this model, the real-world data identified different themes linked to context, process and outcomes. In addition, the personal narratives collected from the research challenged the existing theoretical views which are often detached from the complex and multiple realities of participants, and particular from Eastern Europe.

Based on the above reflections concerning data collection, analysis, research method and study design I suggest future research appreciates the importance of adopting an iterative process in designing the study, seeing positionality and reflexivity as key to interpreting and formulating key findings, and giving attention to the importance of language, translation and confidentiality at all stages of the research process although assuming replication of design and mainly circumstances is difficult to achieve.

Finally, to further refine the findings of the current research it is important that more comparative case studies following an ethnographic approach within nursing are performed. The untold story is an important story to research.

8.4.4 Transferability

Transferability goes beyond developing the same research design for similar situations, with similar research questions (Polit & Hungler, 1999; Robson, 1993; Rose, 1992). To facilitate transferability of the finding to Albania, Kosovo, Turkey, Bosnia & Herzegivina and even Armenia, Ukraine and Georgia, a clear and distinct description of the policy context, the mechanisms employed for compliance, the challenges related to the legislative and professional outcomes and even the combination of these three streams will facilitate the development of an EU Accession Strategy for Professional Development (Seale, 2002; Hirschman, 1986).

Although peer reviews have the same format, the key challenge relates to exploring the united voice for nurses and nursing, the different roles of the nursing leaders, the willingness to engage stakeholders, civil society, into policy design and the ability to give up the medical domination of the healthcare system and the nursing education.

8.5 Summary

Based on the case study findings, it can be argued that EU accession was not a destination but rather a starting point for empowering the nursing leadership advocacy work in eastern European countries. It can be argued that this period of influence on policy was one in which the nursing leadership in the Romanian and Croatian policy processes became strengthened, streamlined and impactful. EU accession negotiations on compliance with the European Directive on Mutual Recognition of Professional Qualifications can be seen as a mechanism to strengthen professional legitimacy claims in relation to education and regulation. However, the social construction of professionalisation goes beyond teaching and regulating the profession.

Although the *Acquis* chapters were provisionally closed for both cases, nursing leaders felt it appropriate to continue their advocacy to convince the European Commission and their governments to re-examine compliance of nursing education with EU educational standards set out in Directive 2005/36/EC. The progress in their lobbying capacity can therefore demonstrate that the EU accession process is a policy window for the nursing leadership and advocacy, rather than policy change impacting on the entire nursing workforce.

The nursing leadership used the EU accession policy window opportunity to different extents but the legislative and professional outcomes also demonstrate variation across both case studies.

The EU accession process created multiple opportunities for the nursing leadership not only to advance a professional agenda during and after EU accession, but also (and equally importantly) increased nurse leaders' knowledge, skills and behaviour concerning advocacy. Policy design and decisions remain the prerogative of government civil servants, mainly physicians by background.

Yet, the TAIEX capacity building mechanism represents a long-term investment in strengthening nursing leadership advocacy role in keeping compliance high on the political agenda, regardless of whether all chapters of the *Acquis* are provisionally closed and EU membership is signed off. Taiex capacity building sessions can be seen as a first steps towards designing a professionalisation strategy, recognising the challenges of the professional boundaries, conflict and legitimation.

The research findings locate nursing leadership within a context-based, process-oriented understanding of what leadership is needed to advance the political agenda of the nursing profession during the EU accession process. In contrast to Romania, the nursing leadership in Croatia learnt how to set the nursing education agenda more effectively through the EU capacity building sessions, lobbying the different state and non-state stakeholders engaged in the process. As a nongovernmental organisation, the CNA transformed its position of exclusion from the EU accession policy process to become a policy advocate. Thus, the organisation was empowered to set the nursing agenda and engage in ministerial decision-making processes, strengthening their leadership to engage citizens in the public and political debate on the position of Croatian nursing education in the EU. The advocacy component was much less evident in Romania but the findings show a very strong voice for civil society and the nursing leadership advocacy to tackle the Commission's reluctance to implement TAIEX recommendations enabling changes in Romanian nursing curricula.

Chapter 9 Conclusions and Recommendations

Following on from the discussion chapter, the primary objective of this chapter is to draw out conclusions and policy recommendations with regard to the study objectives:

1. identification of the context and conditions which have helped or hindered nursing leaders to engage with the EU accession process;
2. exploration of the processes and mechanisms through which nursing leaders have engaged specifically with the *Acquis Communautaire* in the case study countries;
3. mapping out of the policy agenda of nursing leaders and the extent to which policy goals have been achieved in the case study countries; and
4. examination of nursing leaders' views and experiences of the EU accession process and the related policy-making process and outcomes at national level.

The study concludes that the EU accession policy window had a limited impact upon the nursing profession in both countries (though to different degrees), partly because the nursing profession stakeholders lacked the political capital and the networks and resources to formulate a joined-up professional agenda as their conditionality. Moreover, the EU accession mechanisms deployed do not embrace stakeholder engagement in designing policies based on consensus between state and non-state stakeholders. The policy outcomes were determined by the weak TAIEX mechanisms – the peer review and capacity building – alongside the unequal access of the nursing leadership (e.g. professional association, nursing regulator, nursing union, CNO) to the EU accession policy process. Successful *Acquis* compliance goes beyond a dependence on individual governments' willingness, political dynamics 'in Brussels' and the power inequalities between them. Lack of success implies the need for advocacy and leadership strategies to set the political agenda and determine successful policy and professional outcomes. As such it can be argued that advocacy and leadership are key drivers for professionalism.

The key lessons drawn from the case studies led to the formulation of policy recommendations guiding future dynamics of EU accession linked to the contemporary European political debate on the modernisation of Directive 2005/36/EC and the EU health workforce planning.

9.1 Study conclusions related to EU accession as a policy window

Based on the study findings, it can be argued that EU accession was not a destination but rather a starting point for Romanian and Croatian nursing education to comply with European standards as set out in Directive 2005/36/EC. The failure of the nursing leadership to achieve successful legislative and professional outcomes at national level in compliance with EU nursing education standards (fourth study objective) relates to the inherited policy and political context of the Communist regime (first study objective); the weakness of Commission's mechanism to achieve compliance (second study objective); and the lack of unity within the nursing leadership community (professional association, nursing regulator, nursing union, CNO) in setting a joint professional agenda and, equally, engaging with EU accession (third study objective).

9.1.1 Context and conditions for engaging with EU accession

Exploration of the nursing leadership influence on the EU accession compliance processes of Romania and Croatia showed that policy and professional outcomes can only be understood when situated in the wider historical, political and economic context of both case studies (Malhotra & Birks, 2005; Hackley, 2003). In both cases, the regime-specific contextual conditions determined the degree of compliance with Directive 2005/36/EC because the political nursing leadership was being shaped by the contemporary history, including the leadership dynamics inherited from the Communist regime. Moreover, the lack of political capacity to bring the entire nursing workforce in Romania and Croatia towards compliance with the minimum requirements of the Directive was determined by the medical domination of nursing education and the nursing profession; the lack of experience among politicians and policy-makers concerning the position of nursing education within the *Acquis*; and the apparent indifference to nursing as a profession.

There is very little evidence to suggest that the nursing leadership petitioned for professional autonomy (Art. 31 Directive 2005/36/EC). However, medical domination of nursing education reduced the potential for policy influence in both cases since nurses functioned and were treated as medical assistants, a term used for nurses in Romania and Croatia. During the Communist regimes, the term 'nurse' (*infirmieri e*) became associated with a 'cleaning lady', while the title 'medical assistant' scaled up the status of nurses to an assistant of a physician. Consequently, and mainly in Romania, the nursing leadership opposed a return to the term 'nurse', thus making the majority of medical assistants ineligible for the benefits of Directive 2005/36/EC.

It is therefore concluded that the medical-dominated Soviet Semashko model continued to impact on the mind-set of nursing leaders, policy-makers and politicians, thereby maintaining the *status quo* for Romanian and Croatian nurses who graduated prior to EU accession. More worryingly for the single European market, Romanian and Croatian policy-makers, politicians and even some nursing leaders argued that maintaining the *status quo* – keeping medical assistants at secondary education level – would be the best way to prevent nurses leaving Romania and Croatia. As such, it can be argued that limiting free movement for the workforce inhibits claims to professional mutual recognition, which is a core feature of the Acquis. Jurisdictional claims within the Acquis need to be established beyond educational curricula and regulatory frameworks to achieve parity of status across professional boundaries (Abbott, 1988).

In addition to medical domination of the nursing profession in Romania and Croatia, opening of the EU accession policy window was limited by the lack of political capacity and party fragmentation which accompanied regime change. Political intricacies in introducing adaptation to democratic processes in principle were set within an overall culture of operating in accordance with vested interests inherited from the former Communist regime. These became the major barrier for nursing leaders trying to convince politicians of the need for immediate changes in nursing education and the nursing profession now that the EU accession policy window was open. The political policy environment in which nursing became located caused mainly the professional association leaders to be isolated from any political decision-making process. Their advocacy within the nursing leadership met a continuous fear created by arms-length institutionalised forces, preventing them from pushing forward a professional agenda during EU accession negotiations.

It is therefore argued that, in both cases, the nursing profession was marginalised from an accession process dominated by governmental officials (including nurse leaders) and their self-interest agendas. Furthermore, there was a sense in which officials viewed this as a necessary marginalisation: higher profile roles for nurses might have revealed the degree of non-compliance with Directive 2005/36/EC – with repercussions for other parts of the *Acquis* chapters – and created a major source of political embarrassment for government. Similarly, civil society became a biased community infiltrated by former Communist political elites seeking to continue their (indirect) political influence, especially in Croatia.

Nursing leaders therefore withdrew from civil society, thus becoming even more distanced from holding public authorities accountable for their decisions. Evidence on the nursing leadership political tactics suggests that they did not mobilise to establish a clear advocacy strategy. There was no plan to change the mind-set of the former Communist political elites and position the nursing profession and civil society to influence policy and political agendas effectively while the EU accession policy window was open.

It is within this professional and political context that most nursing leaders entered the EU accession policy process. This also forms the contextual background for interpreting the achieved legislative and professional outcomes (fourth study objective) of EU accession.

9.1.2 Processes and mechanisms for engaging with the *Acquis*

The limited opening of the EU accession policy window derives also from the failure to acknowledge weaknesses identified in the TAIEX peer reviews performed prior to EU accession. The findings showed that neither the Romanian and Croatian governments and the Commission negotiating compliance, nor non-state nursing stakeholders, picked up the TAIEX recommendations as a tool for agenda setting. The reports remain confidential to EU and national government officials from the country concerned until signed off by Commission and government. Hence, the Romanian and Croatian nursing leadership had little chance of mounting identified and agreed challenges to their ministry officials. The Romanian professional association did use the TAIEX recommendations to benchmark compliance and formulate an advocacy strategy towards the Commission, but not until two years after completion of EU accession. The Croatian findings showed that the TAIEX peer reviews evaluating legislation and administrative capacity helped in the design of a structured and agreed roadmap for future technical assistance, allocating EU accession funds to address some of the key identified challenges. The Croatian professional association organised three TAIEX capacity building seminars.

The study therefore concludes that the TAIEX peer reviews were more of a theoretical exercise, lacking the power to hold back EU accession when targets were not met. Conversely, the TAIEX capacity building seminars were a valuable mechanism and useful tool during the EU accession process to boost professionalism. These guided the nursing leadership to set out advocacy strategies to address the critical gaps identified in the peer reviews, although the leadership acknowledged that moving TAIEX recommendations up the political agenda was reliant on the

goodwill of civil servants who took TAIEX peer reviews seriously. Policy-makers and politicians continued to draft national nursing legislation without engaging the nursing profession.

The Romanian and Croatian findings also indicated that the TAIEX peer review recommendations were not picked up politically through the Commission's comprehensive monitoring reports so as to enable the European Council and European Parliament to make informed decisions about Romania's and Croatia's readiness to join the EU. Equally, the nursing leadership lacked the political strategy, planning and advocacy required to advance the TAIEX recommendations on the national political agendas of other EU Member States (European Council) agreeing the accession of Romania and Croatia. In this context, the nursing regulators and CNOs of the EU Member States (25 during Romania's accession; 27 during Croatia's) should have had the opportunity to share the TAIEX recommendations with their peers although there is a risk in case transparency is misused. In reality, they are embedded in secrecy and thus hinder the development of the nursing profession in candidate countries. It is therefore concluded that the Commission's comprehensive monitoring reports lack the power to move from legislative endorsement to legislative implementation through governmental commitment. This supports Avdagic's findings (2001) that they do not provide a critical assessment of the implementation of outlined requirements as EU accession is handled almost exclusively by the governments, with the *Acquis* being declared confidential (Avdagic, 2001). Furthermore, TAIEX (led by DG for Enlargement) lacks sufficient authority as non-stakeholders – including European organisations – are not in a position to hold the Commission and national governments accountable for failing to take concrete measures to address the weaknesses identified during the peer reviews benchmarking national nursing legislation with Directive 2005/36/EC.

Finally, it is concluded that government complacency in Romania and Croatia impacted negatively on the uptake of the TAIEX peer review recommendations and the capacity building seminars. Findings suggest that moving the compliance process onto a capacity building footing would have slowed the process overall, jeopardised the EU accession and even raised questions about compliance in other areas of the *Acquis*. Instead, the ministries dealing with EU accession simply did not value nursing highly enough to give the attention necessary to upgrade the nursing workforce. Indeed, there was a deliberate intention to block free movement in order to counteract the danger that the nursing workforce would be lost under the opportunities created by Directive

2005/36/EC. In turn, this would reduce the grip of national governments managing the workforce for health.

9.1.3 Nursing leadership policy agenda-setting and engagement capacity

The discrepancies and conflicts between the different nursing stakeholders engaged in policy-making (nursing regulator, nursing union, professional association, governmental CNO) set the level of influence and determined the extent and direction of their engagement in agenda setting. As the conflicting nursing stakeholders viewed nursing education and professional development differently, two camps within the nursing leadership determined agenda setting and engagement.

1. In Romania, with political support from the nursing union, the nursing regulator (chamber) opposed any upgrading of education and any name change from medical assistant to nurse. In contrast, leaders of the professional association (an EFN member) advocated that nursing education should move from secondary level to higher education. The Romanian professional association became totally isolated from the design of new national legislation as the governmental CNO in Romania also holds a position in the nursing chamber. The TAIEX peer reviews recommended that these two job profiles should be split but no action was taken.
2. In Croatia, the professional association (CNA) and the nursing regulator broadly agreed on the need to upgrade the nursing workforce, supported by the nursing union. However, they fought publicly on how to move from secondary to higher level education. In this case the governmental chief nurse stood by the government negotiator – a physician/politician – opposing any change. The four Croatian nursing leaders involved had all belonged to the CNA prior to 1991 but became competitors as new governmental posts were created during and after the Balkan War.

These conflicting agendas left leverage for politicians pursuing their own agendas and responsibility for acceptance of the legislative and professional outcomes in the hands of civil servants, mainly physicians and lawyers. Hence, failure was a consequence of weak ties between nursing organisations; their limited track records of operating in the EU accession policy environment; and poor political leadership in formulating clear joined-up agendas for developing nursing education and the nursing profession while the policy window of EU accession was open. Arguably, it is the role of the nursing community (professional association, nursing regulator,

nursing union and governmental CNO) to formulate an influencing strategy to professionalise nursing through the legal system, the public arena, and the workplace (Abbott, 1988).

The nursing leadership needed to influence its own community in order to move the nursing agenda onto the political agenda. This proved to be a major challenge for jointly addressing the key professional and regulatory concerns and gaps in national legislation identified in the TAIEX peer review recommendations. In both Romania and Croatia, regardless of the position of each nursing leader, it appeared to be impossible to speak with one voice for nurses and nursing at the time. It is therefore concluded that EU accession did not provide the opportunity to clarify and designate the lines of accountability and responsibility between the nursing regulator, trade union, professional nursing organisation and the governmental CNO at the ministry of health. This led to confusion about their roles and political power, with major conflicts between these four nursing leaders in each country. The diverging views and interests of the nursing leadership concerning the development of nursing education and the profession meant that compliance negotiations were left mainly in the hands of vested interests. These predominated over stakeholder engagement and excluded non-state stakeholders (civil society) from the EU accession policy process.

Agenda setting took place solely between national government and the European Commission. The evidence shows that the credentialing rivalry between the respective ministries of education and of health created new agencies, governmental departments and committees that fragmented the mutual recognition credentialing process. The rivalry over responsibility for the recognition of credentials between the ministries reflected the tensions within the nursing community – the nursing regulator, professional association, nursing union and the governmental CNO each trying to maintain their own influence and control over the recognition of professional qualifications and thereby constraining the future professional development of the nursing profession. It can be concluded that the power differentials and rivalry between the ministries weakened the nursing advocacy efforts and helps to explain why the nursing leadership in Romania and Croatia were unable to capitalise upon the EU accession policy window. The absence of an effective stakeholder engagement approach to set the political agenda, and to design new policies in accordance with the *Acquis*, led to a lower level of acceptance for the legislative policy design. This inhibited professional development according to European standards. Thus, EU accession became a missed opportunity for those in a predominantly female profession to develop their

skills and competencies and hence promote their ability to move within the EU on the basis of mutual recognition of professional qualifications.

9.1.4 Legislative and professional achieved outcomes

Overall, the policy-makers, politicians and nurse leaders interviewed perceived EU membership as a lever to accomplish policy reforms with the potential to bring about positive change, leading to economic prosperity and enabling institutions to move towards a more functional democracy. Nevertheless, participants equally realised that people who had lived for years under a communist regime would need more time post accession in order to change their mentality and feel able to express their own ideas freely. Participants believed that things were already moving on at a better speed and experienced the quality of life improving for everybody during accession negotiations. Participants also considered that EU accession made citizens more conscious of the role of politicians and the fact that they would have a political voice inside the European Parliament and the European Community post accession (2007 for Romania, 2013 for Croatia).

Furthermore, although streamlining and clarification of the different roles (professional association, nursing regulator, nursing union, CNO) created tension and conflicts of power, it can be concluded that EU accession has strengthened nursing leaders' position (especially regulatory and governmental) through the design of a new Nursing Act. EU accession was an important milestone in achieving the necessary credentialing standards and legislation necessary to underwriting new standards of professional practice but which stopped short of achieving occupational closure commonly associated with professional status. As such, findings suggest drawing a distinction between 'advancing a professional agenda' (Kingdom, 1994) and the extent to which the EU accession was perceived as part of a professionalising project (Abbott, 1988). EU accession marks an important milestone in a developmental pathway but one which reflects the transitional status of the profession within Romania and Croatia. As such, the nursing associations have assumed larger roles in advocacy, engaging in political discussions at European level as EFN members. In both cases, it proved difficult to develop nursing advocacy during the EU accession period (governments did not appreciate troublemakers), although the nursing leadership developed positively. Participants indicated key criteria on how they perceived successful nursing leadership – recognising ‘facts and credibility’, 'a united voice', ‘staying in the

field', 'taking concrete actions', 'communicating clearly with the public', 'keeping the wind on your back', 'knowing the movers and shakers' and 'thinking politically' – but the reality of setting the agenda and influencing politicians and policy-makers demonstrates the difference between theory and practice. Participants perceived good networking and speaking with one voice for nurses and nursing to be essential, but these remained professionalism principles rather than implemented in practice.

Instead, the evidence showed conflicting agendas on what the nursing leadership asked and pressed for in both cases. These mainly determined the achieved policy outcomes and future challenges, post EU accession. The Commission and the national governments of Romania and Croatia reached a political compromise to implement a university-level nursing curriculum from the date of EU entry. This implies that the first nurses in compliance with Directive 2005/36/EC graduated in Romania in 2011, and will graduate in Croatia in 2017. Moving a new generation of nurses into a four-year university level education is an important achievement, although the evidence shows that the existing nursing workforce moved through the general system (case-by-case) and not through mutual recognition. For instance, EU data (Commission, 2013) indicate that 373 Romanian nurses were registered through the general system in 2012, 618 in 2011 and 340 in 2010; while only 103 Romanian nurses moved through automatic recognition in 2012, 85 in 2011 and 25 in 2010.

However, as the nursing leadership did not go as far as asking for the entire nursing profession to be upgraded, it can be concluded that there was a deficit in the case for change. In Romania and Croatia, failure to use this opportunity has left the majority of nurses (mostly women) planning to work in another EU MS in a very vulnerable position – the competent authorities will formulate compensation measures on a case-by-case basis and move through the general system (Chapter 2). Consequently, several major challenges remained to be solved post EU accession.

- Implementation of Article 31 of Directive 2005/36/EC setting out and assessing the role of nurses responsible for the planning, delivery and evaluation of nursing care. Nursing education and clinical instruction retain a medical and technically oriented approach; there appears to be no integrated nursing care approach in the nursing care process despite several nursing subjects being introduced in the curricula prior to EU accession.

- Practical training under supervision in hospitals is still included in the curricula but a student nurse cannot operate independently before completion of the one-year internship in several clinical areas. This internship period and the state examination remain part of the educational programmes inherited from the Communist regimes.
- Individuals teaching at the nursing colleges hold master's degrees in a range of disciplines except nursing. Creation of a cadre of nurses qualified to teach nursing at higher/university level remains a challenge for both Romania and Croatia. Development of nursing education at university level implied a focus on investing in 'teaching the teachers' starting post EU accession.
- Regulatory authorities were developed during the EU accession process but there are unclear lines of accountability and responsibility between the nursing regulator, nursing trade union, the professional nursing organisation and CNO at the ministry of health in both Romania and Croatia. These are causing power conflicts which take the focus away from the real challenges facing nurses and nursing. The relationships between the leadership of the relevant professional, trade union and regulatory organisations and the CNO need to be strengthened if they are to contribute effectively to the EU-wide policy process. Arguably, it is the nursing leadership task to resolve these conflicts and to clarify their roles in designing policies compliant with Directive 2005/36/EC.
- Nurses in Romania and Croatia are still called medical assistants and therefore face problems accessing free movement in the EU based on mutual recognition of professional qualifications. These challenges remained untouched and unresolved as both national governments saw the *Acquis* as a potential exit route for nurses lured by better working conditions in other Member States. However, nursing has retained the poor working conditions and very low remuneration of the Soviet Semashko model (less than €250 per month followed by cuts of 25% in 2009, 10% in 2011). This leads nurses to use the general system to move to jobs (other than nurses) in health-care systems in other Member States. The political excuse for not upgrading the entire nursing workforce – that it would result in losing the nursing workforce – has been shown to be irrelevant.
- The Romanian and Croatian governments interpreted harmonisation with the European Directive on MRPQ to include development of new institutional structures and committees, all with diverging tasks within credentialing. EU accession created inter-

ministerial rivalry over responsibility for the recognition of credentials which reflects tensions between the professional nursing bodies.

- The nursing leadership had the ultimate opportunity to set the policy agenda for upgrading education through bridging courses. However, it was not until 2013 that the European Commission, Council and Parliament politically obliged the Romanian Government to install bridging courses – the modernised Directive included a requirement for their introduction using European social funds. Similarly, Croatia's accession proceeds without bridging courses for nurses although the analysis of the TAIEX peer reviews identified weaknesses which will not have been addressed prior EU accession (July 2013).

  Theoretically, there is mutual recognition for Croatian nurses but the experiences collected post EU accession (from July 2013) will indicate whether competent authorities trust the free movement of Croatian nurses throughout the EU. Arguably, it is the leadership task to provide the best working conditions for nurses in the EU.

Overall, it can be concluded that EU accession enabled some legislative and professional changes to be made for the new generation of nurses graduating after the accession of Romania and Croatia but did little to change the position of the majority of nurses graduating beforehand. As such it can be argued that EU accession is about the opportunity to “advance a professional agenda” and being an important milestone in achieving the necessary credentialing standards and legislation necessary to underwriting the nursing education. EU accession marks an important milestone in a developmental pathway but one which reflects the transitional status of the profession within Romania and Croatia.

9.2 Policy recommendations

Based on the study conclusions, policy recommendations are formulated with regard to the study objectives. Specific attention is given to the formulation of leadership and advocacy strategies based on the identified failures to produce successful policy outcomes during the EU accession period.

9.2.1 Context and conditions

Based on the policy and political contextual evidence derived from the ethnographic accounts capturing the experiences and views of Romanian and Croatian nurse leaders and policy-makers, in addition to the knowledge derived from the policy literature, it is recommended that the EU nursing policy research agenda should aim at the following.

- Continuing evaluation of the impact of nursing leadership seizing the policy window of EU accession from the perspective of the context in which policies are designed. Scholarship needs to continue focussing on the EU accession policy window for the nursing profession in candidate countries, including Albania, the former Yugoslav Republic of Macedonia, Montenegro and Turkey; and potential EU candidates such as Bosnia and Herzegovina, Kosovo and Serbia.
- Exploration of developing the Eastern Partnership that currently exists to enhance the EU's relationships with Armenia, Azerbaijan, Belarus, Georgia, Moldova and Ukraine. In those countries where the political elites have no real interest in integrating their countries into the EU, the priority should be reaching out to societies and citizens. EU funding for the Eastern Partnership (€2.8 billion for 2009–2013) should be channelled to ordinary people through NGOs.
- A focus on moving medically dominated nursing education and practice in the Balkan region towards an independent nursing profession as outlined in Directive 2005/36/EC, with the ultimate aim to plan, organise and implement nursing care (Art. 31). The modernised legislative framework for MRPQ – Directive 2013/55/EC – includes eight competencies as learning outcomes, all making reference to the autonomy of the nursing profession. Together with all EU Member States, the professionalisation of nursing becomes key for health systems reforms.
- Exploration of the understanding of EU policy processes and mechanisms as a prerequisite for influencing the EU accession policy and political agenda in order to open wider the policy window for developing nursing as a profession when accessing the EU.
- Acknowledgement of how ‘fear and control’ impacts on nursing leaders' behaviour to set and advance the nursing political agenda. Manipulation and corruption to silence advocates in order to advance EU accession without making any major changes needs to be researched within the context of human rights and democracy.

9.2.2 Processes and mechanisms

Drawing from a range of sources of evidence – including that on compliance mechanisms derived from the ethnographic accounts capturing the experiences and views of the Romanian and Croatian nurse leaders and policy-makers, next to the documentary evidence (mainly the TAIEX peer review, comprehensive monitoring and capacity building reports) – it is recommended that the EU nursing research agenda should pursue the following actions.

- Continue evaluation of the effectiveness of the TAIEX mechanisms for achieving compliance; also, formulating recommendations for the Commission and governments in order to make these mechanisms more fit for practice. Greater transparency in the EU accession decision-making process would strengthen accountability and the processes to achieve compliance.
- Continue evaluation of the uptake of the TAIEX mechanisms by the nursing stakeholders – nursing regulator, nursing union, professional association, governmental CNO – to professionalise nursing beyond the legal aspects by setting the EU accession policy agenda on the basis of the recommendations formulated by the TAIEX peer review experts selected among peers.
- Strengthen the TAIEX capacity building mechanism to develop a multi-level governance initiative to address the national identified challenges for nursing prior to EU accession with the European Council; the European Commission, mainly the DG Internal Market and Services (DK MARKT) and DG for Enlargement; the European Parliament; and civil society. A multi-level governance approach can strengthen professionalism through compliance with the Acquis.
- Create an expert database for EU accession peer reviews and provide capacity building on EU matters – specifically the TAIEX mechanisms and comprehensive monitoring reporting system – to strengthen the EU accreditation system before and after accession. Legal responsibility for monitoring EU accessions must remain with the European Commission (Lisbon Treaty) but it is evident from the conclusions that effective stakeholder engagement is central to successful outcomes.
- Install standard bridging courses for all upcoming EU accession countries, adopted by the European institutions, to guide applicant countries to upgrade their entire nursing

workforce prior to EU accession. There is a need to move away from piecemeal approaches and to use the full potential of the nursing workforce.

- Submit applications for EU accession funds to address the TAIEX recommendations and to provide EU-funded TAIEX capacity building seminars that are crucial for bringing together state and non-state stakeholders, especially when there are conflicting agendas and interests. Capacity building for reaching stakeholder consensus on diverging agendas is needed to improve the policy processes and mechanisms for EU accession.

9.2.3 Policy agenda-setting and engagement

Based on the engagement evidence derived from the ethnographic accounts and the engagement and advocacy literature reviewed, it is recommended that the following items should be included on the EU nursing research agenda.

- Exploration of how to implement an effective stakeholder engagement approach when a national government and the European Commission start negotiations for EU accession. In order to understanding policy outcomes it is crucial to map the state and non-state stakeholder roles assumed during accession; their interests; and their patterns of interactions and influence alongside their potential to reach the objectives.
- Empowerment of nursing stakeholders. The nursing regulator should coordinate credentialing, soliciting the engagement of the professional association, nursing union and governmental CNO for aspects related to their defined roles in policy-making and professional development. Researching, good networking and speaking with one voice for nurses and nursing necessitates empirical evidence.
- Exploration of EU accession conditionality from more of a free movement of health professionals' perspective, linking the single market approach to the human rights and democracy perspective of mobility. This brings onto the human rights agenda the right to move freely in the EU on the basis of mutual recognition. Governments cannot withhold medical assistants' right to benefit from mutual recognition (becoming nurses in EU terms), and to move to other EU Member States, by ignoring the implementation of bridging courses to upgrade the nursing workforce.

9.2.4 Legislative and professional outcomes

Based on the participants' views and perceptions on achieved legislative and professional outcomes, the derived recommendations express their needs for an EU nursing policy research agenda aiming at:

- Researching EU membership and Europeanisation as a lever to accomplish policy reforms and a bridge between empirical evidence and policy-making. Especially in times of austerity, Europeanisation needs to be researched from an economic prosperity, democracy and quality-of-life perspective. Once established more firmly, the European Union Agency for Fundamental Rights (FRA) should mobilise researchers to link free movement and fundamental rights.
- Europeanisation research needs to focus on politicians' role in EU accession and the political voice that national politicians gain in the European Parliament and the European Community post accession. Within this context, nursing research needs to explore the political capital inside the nursing profession and the best ways to invest in strengthening the nursing education through the development of a master degree in political leadership.
- Research to streamline and clarify the different roles of the professional association, nursing regulator, nursing union and CNO is urgently needed to prevent conflicts of power. EU evidence-based guidelines are needed to strengthen the regulatory and legislative position of nursing in all EU Member States, leading to the independence of the nursing profession as set out in Directive 2013/55/EC. Research should be focussed on the case for change, especially consideration of the Article 31 of the modernised Directive 2013/55/EC including a limited set of learning outcomes descriptors supported by a more detailed list of competencies in Annex V. Assessing the role of nurses responsible not only for the planning, delivery and evaluation of nursing care, but also the independency of the profession in the preventive and healthcare system.
- Individuals teaching in the nursing colleges need at least a master's degree in nursing. Greater attention should be paid to the creation and accreditation of a cadre of nurses qualified to teach nursing at higher/university level, within a context of Europeanisation. Investment in 'teaching the teachers' should become an EU accession focus, with financial support from EU funds.

- Eastern Europe should abolish the title ‘medical assistant’ as it endangers free movement based on mutual recognition of professional qualifications. These challenges need to be addressed urgently and agreed at EU level. Nurses within the EU need to move under the sectoral directive (move as nurses) rather than the general system (getting employed as healthcare assistants) in order to capitalise on the EU nursing workforce.
- Harmonisation implies effective and efficient EU credentialing instead of piecemeal responses to inter-ministerial rivalry over responsibility for the recognition of credentials. Consumers – in this case, nurses wishing to move to other EU Member States – need a flexible and safe system facilitating free movement.

9.3 Contemporary European political debate

Taking into account the study conclusions and policy recommendations, these needs to be interpreted within the ongoing EU policy debate of the modernisation of Directive 2005/36/EC and the Commission policy initiatives on EU workforce planning.

9.3.1 Modernised Directive 2013/55/EC in the European single market

Presented by DG MARKT in April 2011, the Single Market Act lays out twelve instruments of growth, competitiveness and social progress. Mobility of health professionals is one of these, implying that free movement of nurses is high on the political agenda for modernising the rules for recognition of professionals’ qualifications by simplifying the procedures and strengthening confidence and cooperation between Member States. In order to strengthen confidence, public authorities need to have confidence in the qualifications achieved at national level by fulfilling the minimum requirements set out in Directive. The quality of nurse education and training is safeguarded by minimum requirements for nurses responsible for general care, particularly that the curriculum consists of at least three years and at least 4600 hours, together with a balance of theory and practice.

During the modernisation of Directive 2005/36/EC, Germany, Hungary, the Netherlands, Malta and Luxembourg have questioned the entry requirements for nursing education with the aim of creating both ‘a theoretical’ and a ‘practical’ nurse with respective entry levels of 12 and 10 years of basic education. Political discussion in the European Parliament and Council concerning a two-

tier system implies that the threshold for compliance could be lowered, thereby bringing Romanian and Croatian secondary-level nursing education into compliance with the EU criteria. Most Member States already require 12 years of basic education before entering nursing, but the nursing profession is worried that the climate of austerity will drive governments to lower the level and even the duration of nursing education. This concern can be countered by the introduction of eight learning outcome descriptors (competencies) with the support of a more detailed competency framework shown in Annex V. Although not yet decided (at the time of thesis submission), the core competencies listed in Article 31 (being legally enforceable) are likely to be:

a. competence to independently diagnose the nursing care required using current theoretical and clinical knowledge and to plan, organise and implement nursing care when treating patients;
b. competence to work together effectively with other actors in the health sector, including participation in the practical training of health personnel;
c. competence to empower individuals, families and groups towards healthy lifestyles and self-care;
d. competence to independently initiate life-preserving immediate measures and to carry out measures in crises and disaster situations;
e. competence to independently give advice to, instruct and support persons needing care and their attachment figures;
f. competence to independently assure quality of, and to evaluate, nursing care;
g. competence to comprehensively communicate professionally and to cooperate with members of other professions in the health sector;
h. competence to analyse the care quality to improve one's own professional practice as a general care nurse.

Therefore, the minimum requirements related to the update of Annexe V of Directive 2005/36/EC are central to educational, scientific and technical progress.

Future EU accessions will need to be evaluated against the modernisation of Directive 2013/55/EC, with the understanding that current EU Member States must implement these requirements by 2017. Within this context, the acquired rights (Article 33) of Romanian nurses imply that the Romanian authorities will need to install bridging courses for nurses who graduated

prior to EU accession in order to prevent total isolation of the Romanian nursing workforce. Prior to EU accession, the Romanian Government argued for its nursing legislation to be designed to prevent the mass migration of Romanian nurses to the West. However, modernisation of Directive 2013/55/EC obliges the Romanian Government to provide evidence to prove that sufficient efforts were made to upgrade the nursing workforce prior to the 2007 accession. The EFN addressed this proactively by preparing a draft bridging course for negotiation with the trialogue: European Commission, Parliament and Council. This element of modernisation of Directive 2013/55/EC was the result of the knowledge and experiences gained from EU accession in both Romania and Croatia. With this academic knowledge, EFN has become a more central player in designing the modernised legislative proposal and increasing its impact and influence on the political decisions throughout the entire negotiation process.

This shows again the importance of positionality: being both a researcher and a lobbyist creates a win-win situation.

9.3.2 EU workforce for health

The European Commission's employment package recognises the significance of the role that the health-care and nursing sectors play in expanding employment opportunities, this being the key driver in providing new and attractive jobs in coming years. But, in order to exploit this potential for job creation, the nursing sector has to overcome several challenges, including: nurse unemployment due to austerity (mainly Spain, Portugal and Cyprus); nursing shortages (e.g. in Belgium, UK); an ageing health workforce with extension of the retirement age; more new recruits in nursing schools but insufficient clinical placement opportunities which increases the deployment of skill labs although hours are not counted for in the Directive 2005/36/EC requirements; emergence of new health-care patterns to tackle multiple chronic conditions; growing use of technologies that requires new skill mixes in nursing; imbalances in skills levels and working patterns; and the need for educational standards throughout the EU (European Commission 2012a; Employment Package, 2012b; EFN, 2013).

DG MARKT modernised the Directive 2005/36/EC proposal currently being discussed in trialogue (Council, Parliament and Commission), together with DG Employment, Social Affairs and Inclusion's upcoming call for a European skills council for nursing and social care. In conjunction

with DG Sanco Action Plan for the EU Health Workforce, these will play a central role in the redesign of European health-care systems (European Commission Action Plan, 2012c).

Over the last decade, WHO, OECD and EUROSTAT have discussed the need for reliable and systematic data collection but still the nursing profession struggles to obtain comparable data for policy-making. Many studies (RN4Cast, PROMeTHEUS, MoHProf) have included nursing in their visualisations and workforce planning, and many ethical recruitment guidelines have been developed over time (by EFN, European Federation of Public Service Unions, WHO), but the nursing profession still faces the same challenges. Austerity measures have made these even worse – causing increased workloads; salary cuts of up to 30%; and the need to do more with less. Recruitment and retention incentives are being cancelled due to cuts in health-care budgets. The EU Employment and Social Situation Quarterly Review (March 2013) confirmed that the EU's social situation had deteriorated further due to the adverse effects of public budget cuts. Nursing is the easiest target for cuts as it is a large-scale profession (3 million nurses in the EU) and therefore has the disadvantage of offering an easy opportunity for finance ministers to find savings. Although the document Strategy of Economic Migration 2010–2020 recognises the importance of an active economic migration policy, and that labour shortages will arise in the context of an ageing population (OECD, 2011), Wistow et al. argue in the Prometheus study that the scale of migration can be considered exaggerated in the minds of policy-makers as the migratory flows never reached the levels anticipated in the early days of EU accession (Prometheus, 2012)

The MoHProf study concluded that “mobility of health workers follows a different pathway than labour mobility in general” (Tjadens et al. 2012:158) and nurses' migration patterns are linked to economic reasons (i.e. better living and working conditions for themselves and their families). However, austerity will put more pressure on individual nurses to find jobs elsewhere in the EU or even in the USA, Australia, Canada and the Scandinavian countries. Romania has the lowest average salary in the EU (€393) and 22% of the labour force earns the minimum wage (€159). Nurses earn €250, and are obliged to have more than one job in order to survive.

Language has been always a barrier for mobility but austerity will force younger nurses to move and learn the new language – as in the case of Spanish nurses in Flanders (VDAB, 2013). Youth

joblessness hit a peak in the EU of 23.6% in January 2013. Paradoxically, nursing shortages exist but nurses are becoming unemployed due to drastic cuts in the health-care sector.

Investments in nursing education (e.g. establishment of bridging courses) are therefore crucial to make citizens, nurses, more mobile. Member States will receive a return on this investment as it addresses one of their biggest challenges – unemployment. Member States will continue to cut health-care jobs, with the lowest educated the most vulnerable. Therefore, EU social cohesion funds need to be used more strategically and systematically to expand services in nursing and the social-care sector. The modernised Directive 2005/36/EC is therefore crucial for regulation of these two sectors. Registered nurses are part of the mutual recognition regime but there needs to be a greater focus on health-care assistants (Contec, 2013) and the advanced practitioners benefitting from the common platforms in Directive 2005/36/EC. Within this context, a skills council is crucial for advancing health-care system reform that leads to a cost-effective integrated care system approach.

It is therefore argued that the Europeanisation research should shift focus from 'post-accession outflows' (PROMeTHEUS) and 'net winners of EU enlargements' (WHO-Europe Observatory) to free movement opportunities based on mutual recognition of professional qualifications, going beyond the current seven sectoral professions. Expansion of the mutual recognition system – to become a guarantee of safe and quality care – requires the learning outcomes for the entire nursing profession (health-care assistants, registered nurses, specialist nurses and advanced nurse practitioners) to be agreed at EU level, preferably in dialogue with the USA, Canada and Australia. Free movement is an opportunity, not a barrier to employment.

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Appendixes

Appendix 1 - The Acquis Communautaire Chapters

Chapter 1. Free movement of goods

Chapter 2. Freedom of movement for workers

Chapter 3. Right of establishment and freedom to provide services

Chapter 4. Free movement of capital

Chapter 5. Public procurement

Chapter 6. Company law

Chapter 7. Intellectual property law

Chapter 8. Competition policy

Chapter 9. Financial services

Chapter 10. Information society and media

Chapter 11. Agriculture

Chapter 12. Food safety, veterinary and phytosanitary policy

Chapter 13. Fisheries

Chapter 14. Transport policy

Chapter 15. Energy

Chapter 16. Taxation

Chapter 17. Economic and monetary policy

Chapter 18. Statistics

Chapter 19. Social policy and employment

Chapter 20. Enterprise and industrial policy

Chapter 21. Trans-European Networks

Chapter 22. Regional policy and coordination of structural instruments

Chapter 23. Judiciary and fundamental rights

Chapter 24. Justice, freedom and security

Chapter 25. Science and research

Chapter 26. Education and culture

Chapter 27. Environment

Chapter 28. Consumer and health protection

Chapter 29. Customs union

Chapter 30. External relations

Chapter 31. Foreign, security, defence policy

Chapter 32. Financial control

Chapter 33. Financial + budgetary provisions

Chapter 34. Institutions

Chapter 35. Other issues

For each chapter of the *Acquis*, the degree of compatibility between national legislation and EU rules is evaluated and provides a common basis for subsequent negotiations between the European Commission and the candidate Member State.

Appendix 2 - EFN Secretary General Speech at European Parliament 1st October 2002

Parlement Européen - Comité des affaires Légales et du Marché Interne - 1er octobre 2002

Audience publique concernant la reconnaissance des qualifications professionnelles COM(2002)119 final

Contribution de l'EFN (PCN)

Cher Président,

Chers Représentants des Citoyens européens,

Chers Madame et Messieurs,

Dans une Europe élargie, 6 millions de citoyens pratiqueront les soins infirmiers et auront la possibilité de travailler dans ce grand espace Européen. Nous ne savons pas aujourd'hui si ces professionnels souhaiteront être mobile, mais si l'outil, qui est la nouvelle Directive, leur permet de le faire, nous obtiendrons un marché du travail flexible, basé sur des standards minimums exigés pour la nature, le contenu et la durée d'éducation des programmes de formation menant à la qualification d'infirmier responsable en soins généraux, tout en ayant la reconnaissance mutuelle de chaque Etat membre. Jusqu'à présent, l'intégration de notre profession au sein de la communauté européenne s'est fait d'une manière à peu prés cohérente car la législation, dans le cadre des directives sectorielles a permis de protéger des standards minima en matière de qualification. Cet état de fait à augmenter pour certains pays le niveau de compétence de leurs infirmières. Si le PCN soutient cette directive, c'est en parti parce que les éléments qui composaient les directives sectorielles ont été repris par la directive proposée aujourd'hui. Il est évident que des mesures plus claires, plus sures et plus transparentes permettront de simplifier des démarches administratives relativement lourdes actuellement. De plus, un processus d'identification plus simple encouragera la mobilité d'infirmières à travers de l'Union Européenne, ce qui est une des façons de réconcilier les manques et l'offre excédentaire d'infirmières. Les exigences linguistiques sont une barrière administrative, mais sont primordiales pour la sécurité

des patients et le transfert et la compréhension d'informations aux patients et à l'ensemble des fournisseurs des services médicaux.

Pour nous il est essentiel de pouvoir garantir un niveau minimum de qualité de soins dispensé à la population européenne compte tenu de l'évolution rapide des technologies et des exigences tout à fait légitime des usagers. C'est pourquoi, des critères qualitatifs plus nombreux permettraient d'augmenter le niveau minimal requis. Notre profession qui a considérablement évolué au cours de ces 20 dernières années n'en est qu'au début de cette évolution. Il faudra prévoir suffisamment de flexibilité et de concertation pour permettre à ce texte de pouvoir jouer son rôle d'encadrement sans pour cela le rendre figé, ce qui irait à l'encontre des objectifs fixés par cette directive. Il est essentiel que les professionnels puissent être au cœur du dispositif qui devrait être mis en place par l'exécutif et qu'ils puissent participer à l'évolution de leur métier. Jusqu'à présent les comités consultatifs assuraient tant bien que mal cette mission. Il faut profiter de cette évolution législative pour renforcer substantiellement l'implication des professionnels dans le dispositif. A l'heure où l'élargissement est à la porte de notre histoire, il est capital que la construction européenne se fasse avec et pour les citoyens européens si l'on veut une Europe forte et unie. Notre association qui représente l'ensemble de la profession à l'échelle européenne doit pouvoir participer d'une manière responsable et active à cette construction.

Il est dommage que la question des spécialités ne fasse pas partie du texte car c'est actuellement le point le plus délicat à traiter dans chacun des pays concerné. Espérons que la commission puisse se pencher sérieusement sur ce problème.

En conclusion, la nouvelle directive doit permettre de garantir une grande transparence en permettant un dialogue permanent entre la profession et la Commission. Cette tâche ambitieuse doit être accompagné par des mesures concrètes et réalistes afin de pouvoir atteindre les objectifs fixés lors du Conseil Européen de Lisbonne.

1 octobre 2002

Paul De Raeve

Secrétaire général du Comité Permanent d'Infirmières de l'UE

Appendix 3 - Directive Annex 5.2.1

V.2. NURSE RESPONSIBLE FOR GENERAL CARE

5.2.1. Training programme for nurses responsible for general care

The training leading to the award of a formal qualification of nurses responsible for general care shall consist of the following two parts.

A. Theoretical instruction

a. Nursing:

— Nature and ethics of the profession

— General principles of health and nursing

— Nursing principles in relation to:

— General and specialist medicine

— General and specialist surgery

— Child care and paediatrics

— Maternity care

— Mental health and psychiatry

— Care of the old and geriatrics

b. Basic sciences:

— Anatomy and physiology

— Pathology

— Bacteriology, virology and parasitology

— Biophysics, biochemistry and radiology

— Dietetics

— Hygiene

— Preventive medicine

— Health education

— Pharmacology

c. Social sciences:

— Sociology

— Psychology

— Principles of administration

— Principles of teaching

— Social and health legislation

— Legal aspects of nursing

B. Clinical instruction

— Nursing in relation to:

— General and specialist medicine

— General and specialist surgery

— Child care and paediatrics

— Maternity care

— Mental health and psychiatry

— Care of the old and geriatrics

— Home nursing

Appendix 4 - Letter to Polish Minister of Foreign Affairs

Wlodzimierz Cimoszewicz
Foreign Minister
Aleje Szucha 23
00 - 580 Warszawa
POLAND

Brussels, 23 December 2002

Concerns: Poland's accession to the EU and the Implementation of EU nurses in general care Directives.

Dear Minister Cimoszewicz,

The European Federation of Nurses Associations (EFN), which represents professional nurses' associations across Europe (including current EU member states and accession countries), is writing to express its grave concerns about nursing qualifications in Poland and their automatic recognition in Europe under the accession arrangements.

The expert "peer review" group appointed and funded by the European Commission to look at implementation of the nursing and other sectoral directives in the accession countries reported only a few months ago that in the case of Poland there were serious deficiencies in relation to:

- Length of training for basic nurses registration
- Inappropriate division of hours of study between theory and practice
- A general lack of sufficient nurse-led nursing education institutions
- Lack of evidence that changes are being implemented at a reasonable pace

We are now seeking urgent reassurances both from yourselves on a number of points below, in order to maintain the quality of nursing care across Europe, to ensure that the efforts of the other accession countries to reach the minimum standards laid down in 'The nurses in general care directives' are not being undermined by making special exceptions for Poland - which has the largest nursing workforce of the candidate countries, and to avoid the possibility in the future of Polish nurses being side-tracked within an enlarged Europe out of professional fears for the validity and transferability of their nursing qualifications.

1) Master Degree Nursing Programme in Poland

We urge the minister to ensure that heads of academic nursing departments and nursing faculties look at the master's degree programme in nursing as a matter of urgency and ensure that a re-structuring of the programme takes place to account for the EU Directives that govern pre-registration nurse education. EFN considers that nursing education at masters' level is important, in relation to the preparation of nurse teachers and advanced specialist practitioners, and that these post-registration academic programmes need to be expanded, in line with other European countries and requests that the minister facilitates the nursing departments to deliver these programmes. EFN believes that this education should not replace basic nurses qualifications.

2) Bachelor Degree Programme

EFN is aware that in preparation for adaptation to the EU nursing directives and in keeping with a general restructuring of higher and further education in Europe, a series of three year nurse education programmes were piloted in Poland with the financial and technical assistance of the EU and nurses from various EU countries. These piloted programmes met the EU nursing directives requirements and it was assumed that they would be introduced into the country as a viable programme. Unfortunately, these well prepared programmes have been discontinued and replaced with the current degree programme which does not adhere to the theory/practice split required in the EU nursing directive or to the necessary content.

EFN believes therefore that the B.Sc. nursing qualifications obtained in Poland unless modified according to the EU Directives should fall under the General Systems directive as they do not meet the minimum standards of the 'nurses in general care directives' which other European countries have had to comply with. Nursing institutions across Europe are extremely worried about this situation. Therefore, EFN strongly urges the Ministry of Health and Ministry of Education in Poland, the Polish Nurses Association and the Polish Nurses Chamber and heads of Nursing Departments in Universities to urgently work together on adapting this B.Sc. nursing programme to meet the directives requirements and to demonstrate a readiness to implement the required changes for the present intake of Bachelor degree nursing students, and for all future nursing student intakes. Progress in this area will be closely monitored by EFN and professional European and international nursing institutions.

3) Traditional nurse training in Poland

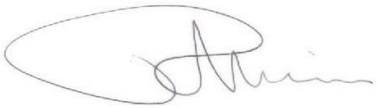
EFN is aware that there have been several forms of nurse education conducted in Poland in the past, none of which adhered even closely to the EU nursing directives. Fortunately, these programmes have been largely discontinued and replaced by the Bachelor degree (see above). There remains however an urgent need for instituting conversion/bridging courses for these nurses to equate their present qualifications to the requirements of the nursing directive. Until this additional training has been completed those nurses who completed traditional nurse training programmes must fall under the General Systems directives as a short term measure. Anything less than this would be reckless and unsafe. EFN urges the minister to consider implementing these bridging courses as the practice of professional nursing in Europe is considerably more sophisticated and demanding than the Polish two year nursing programmes or even pre-matriculation programmes could ever have anticipated, and the practical recognition of life-long learning in no measure demeans the value of Polish traditionally trained nurses, rather it provides these nurses with an opportunity to gain extra skills and knowledge to play a full part on the European healthcare scene. It would also be grossly unjust towards these traditionally trained nurses to even potentially expose them to professional work demands which are far beyond anything that they were educated for.

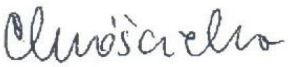
EFN would encourage the Polish Government to support bridging programmes which will not financially burden the already very badly paid Polish nurses, in order for them to upgrade their current Polish nursing qualifications to meet the EU standards. Obtaining this qualification is an important step for Polish nurses for economic and professional reasons. Nurses who wish to obtain EU nursing qualifications should be given the opportunity to take these bridging courses, as other nurses in European countries.

As a result of these concerns EFN intends to propose a meeting between the Polish Ministries of Health and Education, the Polish Nursing Chamber, the Polish Nurses Association, and the heads of nursing departments in Poland to enhance communication and consultation among the various interested parties and to seek to resolve some of these problems. Many of the nurses we speak to who are working in the education system in Poland, are keen to introduce the necessary bridging courses to enable nurses trained in previous years to obtain EU recognition. They would welcome the opportunity to encourage among nurses the philosophy of life-long learning and they have many practical suggestions for implementing the necessary changes to the work, education and management of nursing in Poland, at local and national and governmental level. These

individuals need to be consulted as a matter of urgency. Indeed the conduct of nursing affairs in Poland needs to be given over to qualified professional nurses, in keeping with the recommendations of WHO Munich Declaration and the spirit of European nursing organisations. Otherwise nursing policies in Poland will be constantly out of step with the rest of Europe and Polish nurses will have no representation or voice in Europe or the international healthcare scene.

Yours sincerely,





EFN President

President of Polish Nurses Association

Appendix 5 - Interview Schedule Romania

SECTION 1: OVERALL PROGRESS MADE IN JOINING THE EU? **PREAMBLE**: You have played an important role in the accession negotiations of Romania to the European Union. Romania joined the European Union on the 1st January 2007 and now after 21 months, are you willing to make your own evaluation of the progress made overall?		
Q. Can I start off by asking you to tell me your vision on the progress made for Romania in joining the EU? **Q.** What were the main strategies leading to success? **Q.** You gave me some concrete examples, but can you now tell me what success mains?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *Although these questions are more general introduction questions to get respondents talking and relaxed, I need to get a better understanding of the overall achievements by joining the EU.* *I hope to receive some concrete examples which will enable the interviewee to define what success is.*	Notes
SECTION 2: THE CONSEQUENCES OF EU ENLARGEMENT **PREAMBLE:** Ok, you have described to me some key successes due to enlargement of Romania to Croatia, but can you now describe to me, after enlargement, what the main negative effects are for Romania in joining the EU?		
Q. So, having a view on some success stories, can you describe some negative stories related to Romania joining the EU? **Q.** What do you think should have been done during the accession to prevent these negative consequences to happen?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *These questions are intended to know the negative impact of enlargement.*	Notes

SECTION 3: LEGISLATIVE NURSING OUTCOMES **PREAMBLE**: Within the context of the thesis I focus on the implementation of Directive 36, the Directive on Mutual Recognition of Professional Qualifications. Has a new law been developed and what are the main changes for the nursing legislation in Romania?		
Q. Are the Directive Criteria implemented? **Q.** The criteria make reference to professional autonomy, how is this achieved? **Q.** Is nursing education, after enlargement at vocational level or higher/university level? **Q.** Who are the winners and losers?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *These questions are intended to evaluate if the Directive 36 is implemented and focuses on the main 4 Directive criteria.* *Next to having a nursing law, it is crucial important teasing out if this new law is implemented in practice, in all nursing schools, private and public.*	Notes
SECTION 4: PROFESSIONAL OUTCOMES **PREAMBLE**: Next to the legislative outcomes, I want to find out how the nursing profession evolved after accession of Romania to the EU.		
Q. Can you identify to me the main changes in the nursing profession after accession to the EU? **Q**. What about the synergies between the NNA, the Chamber and the Nursing Union? Is there any difference in their relation after accession to the EU? **Q**. What is the impact of EU accession on the individual nurse?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *This section is about the impact of the accession on the nursing profession. I want to tease out how the nursing profession has evolved due to accession to the EU.*	Notes

SECTION 5: THE FUTURE **PREAMBLE**: Our interview is coming to an end but I would like to give you the opportunity to formulate your overall verdict on the leadership of nurse leaders within an enlarged European Union.		
Q. What was the leadership of the nursing community in the accession of Romania to the EU? **Q**. Are the nurses ready taking up leadership in the health systems? **Q**. How fits Civil Society the equation of leadership and policy-making?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *This section is about leadership and the way the nursing community applies leadership to run the health system.* *Furthermore, I want to tease out, after enlargement how the nursing community fits in Civil Society.* *Finally, I want to know how civil society have changed since the accession of Romania to the EU*	Notes

SECTION 1: YOUR ROLE IN POLICY MAKING **PREAMBLE**: Your personal views on issues related to policy-making are of significant importance to my research. Your personal background, especially during the Tito Regime, becoming the policy-maker you are today, is of importance for me to understand better the policy-making process of the European Union in the years to come.		
Q. Can I start off by asking you to tell me a bit about your current job and professional role, and how you are involved in national and European policy making in relation to the nursing profession? **Q.** And can I ask you more specifically how you developed an understanding of how policies were influenced in your country during the Tito regime and was this experience useful in the negotiation processes within the TAIEX mission peer reviews? **Q.** What is your perception about the constitutional arrangements within which your government operates, the rules of the game and the bureaucratic machinery associated with EU legislation?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *Although these questions are more general introduction questions to get respondents talking and relaxed, I need to get a better understanding of the respondent trinity of ideas surrounding enlargement.* *What the perception of the respondent is in terms of her/his role in nursing and policy-making at national and European level and to get a first impression of the level of influence she/he has around policy making within the EU enlargement process.* *What are the trinity of ideas, interests and institutions surrounding the enlargement process?* *Also to get a general idea, at the outset, of the key topics of interest from the respondent's perspective I want to follow up on in more details in the later sections.*	Notes

Appendix 6 - Interview Schedule Croatia

SECTION 2: YOUR BACKGROUND – HOW YOU GOT WHERE YOU ARE? **PREAMBLE**: Ok, part of what I'm really interested in for my thesis is how people like you got to where you are; how you came to have the role you've just described in relation to the nursing profession in your country and its involvement in the EU enlargement negotiations. So, if it's ok, I'd like to ask you a few questions about your personal background and history as a nursing leader/policy-makers, and how you developed your thinking in relation to policy-making nationally and in relation to the EU.		
Q. So can I ask you to tell me a bit about your career development and how you got into the role that you have in policy making/nursing profession? **Q.** It is important for me to understand how you got acquainted with the policy-making institutions during your career development and how do you think the Tito regime has influenced your approach in policy-making? **Q.** What is your perception of the policy making process during the Tito regime and what are your views on complying with the *Acquis Communautaire* controlled by the European Commission? **Q.** Why is it so important for Croatia to become a member of the European Union and how do you see its position developed over next 10 years?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *These questions are intended to unfold the policy environment and political context in which policy-makers and nurse leader grew up to maternity during the Tito regime.* *I'm interested to find out more about the respondent membership and political involvement in the Tito regime.* *Finally it is important to find out the impact of family, friends and the secret police during the period of Tito.*	Notes

SECTION 3: HOW YOU WORK AND HOW YOU INFLUENCE POLICY AGENDAS? **PREAMBLE**: I presume that the Western European literature on policy-making was not available during the Tito regime, the time you became mature in policy-making at national level, and I presume also that it was difficult for you to go abroad, and even if it was possible, to come back and implement western European models within your national political context.		
Q. Are my presumptions correct? **Q.** You talked about your history and background and the strategies you have set out, and therefore I wonder if you could tell me a bit more about how that has helped you or hindered you in relation to the policy making process surrounding the EU enlargement process? **Q.** Coming back to the process of influencing the agenda of the TAIEX missions, what did you do to get what you wanted? **Q.** Where did you learn to influence politics and policies? **Q.** How did you gain confidence in your ability to engage with and influence politicians and policy-makers?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *These questions are intended to understand better agenda setting, the lobbying strategies used during the negotiation process surrounding the TAIEX missions. For example, what does the process of engagement entails? And what networks, informal and formal ones, did you develop or used to influence the policy-making processes during the Tito regime?*	Notes

SECTION 4: NURSING PROFESSION AND AGENDA SETTING **PREAMBLE**: Finally, I would like to explore with you more in dept the status and the influence of nursing as a profession in your country in order to better understand the leadership needed to obtain successful policy outcomes.		
Q. How was it for the nursing profession in terms of the level of influence during the TAIEX mission by which National nursing legislation had to be brought in line with the EU Nursing Directive? **Q**. You described to me how the nursing profession moved up their agenda in the policy process and what tactics they used to do this. Now, was the nursing profession successful in achieving its goals? **Q**. And if yes, what were the main outcomes? **Q**. And if no, what was the reason for not achieving them? **Q**. How do you see the role of the nursing profession in the European Union policy-making process?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *This section is about the involvement of the nursing community and in particular the leaders of that community in the EU enlargement of Croatia and the process of policy-making that surrounds enlargement. These questions are intended to find out how the nursing profession was engaged in the Acquis Communautaire and the TAIEX mission peer reviews.*	Notes

SECTION 5: The Future **PREAMBLE**: Our interview is coming to an end but I would like to give you the opportunity to formulate your overall verdict on the level of influence nursing leaders have on the policy making and EU enlargement process.		
Q. Which are the future challenges the nursing profession is facing and how do you see the role of the National Nurses Association, the Nursing Chamber, the Nursing Union and the Governmental Chief Nurse in the development of the nursing profession as an effective lobbying force? Q. How would success in policy making look like from your point of view and has it been achieved? If not, why not and what should the nursing profession do to increase its impact on policy making and the EU enlargement process? Q. Presuming Croatia will join the European Union in 2009, how do you see the Croatian position within this group of 27 Member States in the next ten years from now? Q. If there is anything you would like to add that hasn't been covered so far?	**Interviewer Guide (i.e. these are not exhaustive prompts)** *This section is about identifying the criteria to measure the involvement of the nursing community in the process of policy-making that surrounds enlargement. These questions are intended to find out more about the legitimacy, the impact and the responsibility of the nursing profession related to the challenges, the proposals and the political culture. Explore more what the respondent has to add.*	Notes

Appendix 7 - Law 307 - June 28, 2004

Law 307 - June 28, 2004 - Published in the Official Monitor, Part I, no. 578 - 06/30/2004, regarding the practice of the Nurse and midwife professions, as well as the organization and functioning of the Order of Nurses and Midwives in Romania

CHAPTER I General stipulations

SECTION I The Practice Of The Nurse And Midwife Professions

Art. 1. The Nurse and midwife professions are practiced on the Romanian territory in accordance with the stipulations of the present law, by individuals owning an official qualification title for the profession of Nurse and by individuals owning an official qualification title for the profession of midwife respectively. The above mentioned individuals might be:

a) Romanian citizens;
b) citizens of an European Union State, of a state belonging to the European Economical Space or to the Swiss Confederation;
c) the spouse and first degree descendants supported by a citizen of one of the states mentioned at b), who legally carry remunerated or unremunerated activities on the Romanian territory, regardless of their citizenship;
d) The long-term resident statute beneficiaries granted in compliance to the European Union regulations by one of the states stipulated at b).

Art. 2. In the present law, the terms and expressions below have the following meanings:

a) The expression "citizens of a European Union state, of a state belonging to the European Economical Space or to the Swiss Confederation" also includes, by assimilation, those individuals who relate to the situations stipulated by letters c) and d).
b) Exclusively, the expression "origin country" and, according to the case, "host country" is a state of the European Union, a state belonging to The European Economical Space or to the Swiss Confederation;
c) The expression "Nurse" refers to generalist Nurses and to Nurses trained in other specializations, established by the standards regarding the definition of professional titles and their related fields of activity. The term "midwife" refers to an individual owning an official

qualification title for the profession of midwife, as stipulated by Annex 2, and offers medical assistance the content and characteristics of which are mentioned in Article 6;

d) By "official qualification title in the Nurse profession" we understand the diplomas mentioned in Annex 1, and by "official qualification title in the midwife profession" we understand the diplomas mentioned in Annex 2.

Art. 3. (1) The official qualification titles for the profession of Nurse and the official qualification titles for the profession of midwife obtained outside the Romanian territory, outside the EU member states, outside the states belonging to the European Economical Space or outside the Swiss Confederation states will be validated in accordance with the law.

(2) Exception to Paragraph (1) are the official qualification titles in the generalist Nurse profession and the official qualification titles in the midwife professions which are certified by one of those states.

Art. 4. (1) the activities specific for the Nurse profession are developed in Romania with the professional titles stipulated by Annex 1, C, in accordance with the acquired professional qualification.

(2) Health care activities that aim to ensure maternal health and new-born health are to be developed in Romania with the professional title of midwife, as stipulated by Annex 2, B.

(3) The provisions stipulated by paragraphs (1) and (2) also apply to citizens of an EU member state, of the European Economical States or of the Swiss Confederation, owning an official qualification title in the Nurse profession, or in the midwife profession respectively, and who practice their profession in Romania.

Art. 5. The content and characteristics of the generalist Nurse activities are:

a) Determining the general health care needs and supplying general health care, of preventive, curative and recuperatory nature, according to the standards elaborated by The Ministry of Health, in collaboration with The Order of Nurses and Midwives in Romania;

b) Administrating treatment, according to the doctor's prescription;

c) Protecting and improving health, elaborating programs, developing health education activities and facilitating actions for protecting health in what are considered as risk groups;

d) The participation of authorized generalist Nurse as trainers to the theoretical and practical education of generalist Nurses within continual training programs;

e) The optional development of research activities in the general health care field, by authorized generalist Nurses;

f) The preparation of auxiliary health staff;

g) The participation to environment protection;

h) Preparing written reports as to the development of specific activities.

Art. 6. The content and characteristics of the midwife profession are: Confirming pregnancy and performing the necessary tests, in order to monitor the evolution of a normal pregnancy;

a) Prescribing or recommending necessary examinations, meant to discover in time a risky pregnancy;

b) Ensuring the complete preparation for the mother for birth, developing health education activities and initiating and developing programs for educating the future parents;

c) Giving hygiene and nutrition advice;

d) Administering treatment, according to doctor's prescription;

e) Nursing and assisting the woman in labor and checking the intrauterine status of the fetus, by adequate clinical and technical means;

f) Assisting the natural birth process, at the client's home or in sanitary units, in case of cranial presentation and performing episiotomy if needed and, in case of emergency, assisting birth process in pelvic presentation;

g) Identifying signs that announce anomalies in case of the mother and the baby as well and that need a doctor's intervention, that midwife has to assist in such situations;

h) Taking the necessary emergency steps, in the doctor's absence, for manual extraction of the placenta, followed by a manual uterus check-up;

i) Examining the new-born, that the midwife will nurse, initiating the necessary steps and, in case of need, performs immediate resuscitation;

j) Nursing and monitoring the mother in the post birth period and giving her all the necessary recommendations in regards to nursing the new-born, to insure his/her optimal development;

k) Developing written reports in regards to his/her activities;

l) Giving information and counseling in regards to family planning;

m) Participating to theoretical and practical development programs for midwives, as well as to programs for educating the auxiliary sanitary staff;

n) Optional development of research activities by authorized midwives.

Art. 7. (1) The activities stipulated by articles 5 and 6 will be developed by assuming responsibilities of generalist Nurses and midwives in terms of planning, organizing, evaluating and delivering services, as an employee and/or freelancer.

(2) The activities developed by Nurses with other specializations will be developed with responsibilities in regards to all the acts and techniques that make the object of the specialization, developed as an employee and/or freelancer.

Art. 8. The control and the supervision of the Nurse and midwife professions are the responsibility of the Ministry of Health and The Order of Nurses and Midwives in Romania, which will be called Romanian competent authorities.

Art. 9. The professions of Nurse and midwife can be practiced by individuals mentioned in Art. 1, who fulfil the following conditions:

a) Own an official qualification title for the profession of Nurse, stipulated in Annex 1, for the profession of Nurse, and respectively own an official qualification title for the midwife profession, as stipulated in Annex 2, for the profession of midwife;
b) Are medically adept to practice profession;
c) Are authorized by the Ministry of Health;
d) Have not been convicted of any sort of intentional offence to humanity or to life, in circumstanced linked to the profession practice or to the individual that needed rehabilitation.

Art. 10. (1) The authorization for the practice of the Nurse and midwife professions on the Romanian territory is granted in accordance with the regulations in regards to Nurses and midwives' matriculation in the Unique National Registry, elaborated by the Ministry of Health, in collaboration with The Order of Nurses and Midwives in Romania.

(2) The free medical practice authorization is issued by the Ministry of Health based on the following terms:

a) The official qualification titles for the Nurse profession and, respectively, the official qualification titles for the midwife profession, stipulated by the present law;

b) The criminal record;

c) The physical and mental health record;

d) The approval of The Order of Nurses and Midwives in Romania.

(3) Generalist Nurses and midwives that are citizens of a EU member state, of a state belonging to the European Economical Space or of the Swiss Confederation, established in Romania, will practice their profession on the basis of the documents issued by the Romanian competent authorities, as stipulated in art. 30.

(4) In case of temporary practice of the professions in Romania, generalist Nurses and midwives that are citizens of a EU member state, of a state belonging to the European Economical Space or to the Swiss Confederation, established in one of these states, are excepted from the obligation of obtaining the free medical practice authorization. The access to the activities of generalist Nurse and midwife professions, during the service rendering period, is granted as stipulated by art. 34.

Art. 11. (1) Nurses and midwives will develop their activity in accordance with their professional training, in the public and/or private sector, and in collaboration with the health nursing services suppliers.
(2) The activities of Nurses and midwifes is developed within the medical team or independently for health care purposes. The Nurse and the midwife will acknowledge the roles of other team members and try to maintain amiable relationship within the team.
(3) Nurses and midwives who fulfill the stipulations in Art. 1 and are established in Romania can develop their activities as owners or partners in independent practice offices for health care.
Art. 12. (1) In practicing the profession, Nurses and midwives are not public clerks.
(2) Licentiate Nurses and midwives can be tutors in superior study institutes that train Nurses and midwives, as well as members of a research team within research institutes.

Art. 13. (1) Hiring and professional or administrative promotion of Nurses and midwives in the public and private health system will be done in accordance with the law.
(2) In case of risks involved in the professional activities, protection of Nurses and midwives will be dealt with by the employer, through health insurance institutes. In case of free independent

practice for health care, Nurses and midwives are obliged to sign civil responsibility insurance for professional malpractice.

Art. 14. (1) If a Nurse or a midwife stops their professional activity for more than 5 years, The Order of Nurses and Midwives in Romania will retest their professional competence, so that they can resume their activity.

(2) The procedures in regards to the modalities and conditions of professional level evaluation and certification are established by the Ministry of Health and by the National Council of The Order of Nurses and Midwives in Romania.

(3) The stipulations of art. (1) are also applied in case of Nurses and midwives who are citizens of a EU member state, of a state within the European Economical Space or of the Swiss Confederation, established on the Romanian territory.

Art. 15. The Order of Nurses and Midwives in Romania, through the president of the respective branch, is entitled to announce, if case may be, the judicial authorities or the competent authorities, to pursuit and to convict the individuals who use the title or the qualification of Nurse or midwife without being entitled or those individuals who practice the profession illegally.

Art. 16. In practicing the profession, Nurses and midwives should respect the dignity of a human being.

Art. 17. Nurses and midwives have the obligation to keep professional confidentiality, except for the cases stipulated by the law.

Art. 18. Nurses and midwives have the obligation to take steps to administer first aid, regardless of the person, place or circumstances it is needed.

Autor OAMR at 12/07/2006 01:58:00 AM - Labels: Legislation

Appendix 8 - General Care NURSES IN CROATIA

The profession of MEDICINSKA SESTRA or NURSE (GC Nurses in EU) in the Republic of Croatia has been regulated by the Healthcare Act and the Nursing Act.

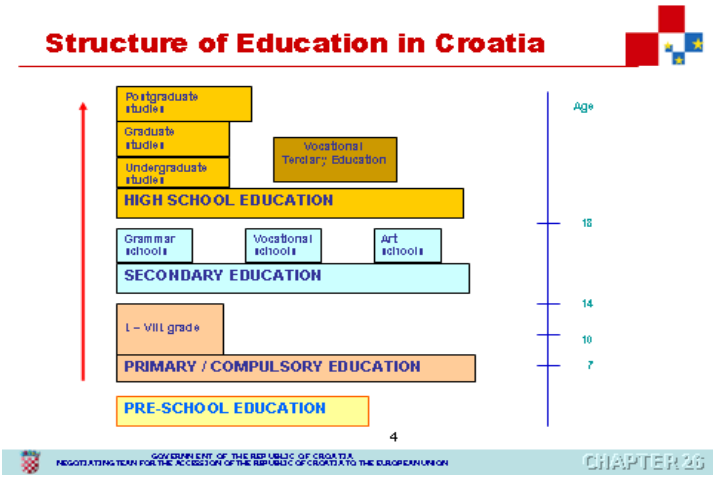
At the present time in Croatia there are two levels of education that nurses for general care can be provided with:

(i) secondary school-vocational school education that provides for the basic nursing education followed by compulsory Internship;
(ii) three-year undergraduate nursing studies at the University level, Professional bachelor University studies.

Training structure

The formal education system in Croatia starts with the eight years of compulsory elementary school.

Education continues within secondary school programmes that last four years. There are three types of secondary schools in Croatia: Grammar schools (providing for general education), Vocational schools (providing for the basic training for certain type of professions) and Art schools.



In the Croatian educational system today there are 23 Medical high schools (that provide for nursing education) that fall within Vocational schools group. The education in vocational schools is in principle divided into general subjects and vocational subjects. General subjects are taught mainly during the first two years of secondary education while the vocational subjects are mainly concentrated in the last two years.

Regarding the general subjects in Medical school's nursing programmes they encompass minimum 1956 hours of theoretical instruction and 274 hours of exercises. Vocational subjects are taught through 1393 hours of theoretical training and 142 hours of exercises plus 643 hours of practice amounting to 785 hours of clinical instructions.

Once the programme is finished there is a Vocational exam (Matura in Croatia) that has to be passed and then the person has the right to enter the nurses register but cannot enter and exercise profession independently.

In accordance with the *Ordinance on internship of health professionals* (OG 18/94 & 20/94), healthcare professionals (encompassing nurses) continue their education in healthcare institutions by receiving training to independently carry out their professional work, which is considered to be an integral part of their education although it is provided after the completion of the formal training in educational institutions. This compulsory Internship lasts one year, and in the case of nurses it consists of 480 hours of theoretical instructions and 1440 hours of practice that amounts altogether of 1920 hours of training. The training is held exclusively in healthcare institutions at the patient's bedside under supervision of an authorised mentor.

At the end of the Internship programme there is the State Exam, final exam that allows the professional nurse to enter and exercise profession independently. This exam consists of general and vocational part. General part of the exam deals with legal matters (laws governing health sector) and vocational part deals with whole of the nursing programme including the internship.

After finishing this programme the person in Croatia is considered to have passed the basic nursing education and has the title of *MEDICINSKA SESTRA-MEDICINSKI TEHNIČAR* (NURSE).

When comparing the programme of basic training in Croatia with the corresponding programme for basic training for GC Nurses given in the Annex V.2. of the Directive 2005/36/EC; 2073 hours of theoretical training, 117 hours of exercises and 2013 hours of practice correspond in substance, thus making 4203 hours of education being relevant for the recognition of the title in EU Member States.

In the table below please find the comparison of the distribution of subjects, the proportion of theoretical and practical training, hours of each, and the total number of hours during the whole

basic training programme for nurses in Croatia (secondary school and compulsory Internship) to the Directive 2005/36/EC requirements.

The education system in Croatia provides for the continuation of training in nursing in order to gain the title of *VIŠA MEDICINSKA SESTRA* (HIGH NURSE). That education is provided within the professional bachelor University programmes in three Croatian Universities (Rijeka, Split and Osijek) and in one specialised Medical School for Nurses training in Zagreb.This so-called nursing studies last three years and encompass 4 615 hours of training (as well given as 180 ECTS points). The training is consisting of 1 265 hours of theoretical instructions and 1 435 hours of clinical training. In addition 1 915 hours are spent for students' preparations for all types of active training, study of literature required for active participation in the training, and study of scientific literature for exams. After finishing this programme the person obtains a bachelor diploma in nursing.

Data presented in the table according to the official document: "Education plans and framework programmes for the Health sector" published by the Ministry of Science Education and Sports

No.	Name of the subject in Croatian	Name of the subject in English (the ones set in the Directive 2005/36/EC Annex V.II. given in red)	Training program for nurses responsible for general care in hours		
			Theoretical instruction	Clinical instruction	
				Exercise	Practice
GENERAL SUBJECTS					
1	Hrvatski jezik	Croatian Language	548		
2	Strani jezik	Foreign Language	274		
3	Povijest	History	297		
4	Vjeronauk/Etika	Nature and ethics of the profession	140		
5	Politika i gospodarstvo	Social and health legislation Principles of administration	32		
6	Zemljopis	Geography	105		
7	Tjelesna i zdravstvena kultura	Fitness and health education		274	
8	Matematika	Mathematics	140		
9	Fizika	Biophysics, biochemistry and radiology (basic physics and biophysics)	140		
10	Kemija i biokemija	Biophysics, biochemistry and radiology (basic chemistry and biochemistry)	70		
11	Biologija (s genetikom)	Biology (with Genetics)	140		
12	Računalstvo	Informatics	70		
VOCATIONAL NURSING SUBJECTS					
13a	Zdravstvena njega I	General principles of health and nursing	140	35	
13b	Zdravstvena njega II	General principles of health and nursing	70	20	120
13c	Zdravstvena njega:	Nursing care in relation to:			
13c1	interni bolesnici	General and specialist medicine	71		95
13c2	psihijatrijski bolesnici	Mental health and psychiatry	15		16
13c3	neurološki bolesnici	General and specialist medicine (neurological illness)	17		20
13c4	infektivni bolesnici	General and specialist medicine (infection illness)	17		20
13c5	zdravo i bolesno dijete	Child care and paediatrics	35+31	20	60
13c6	starije osobe	Care of the old and geriatrics			20
13c7	kirurški bolesnici	General and specialist surgery	31		60

13c8	porodništvo i ginekologija	Maternity care	16		16
13c9	Onkološki bolesnici	General and specialist medicine General and specialist surgery (oncology illness)	15		20
13c10	Bolesti osjetila (ORL, kožne bolesti, očne bolesti)	Nursing care in dermatology, othorynolaryngology and ophthalmology			36
14	Latinski jezik	Latin Language	140		
15	Anatomija i fiziologija	Anatomy and Physiology	105		
16	Patologija i patofiziologija	Pathology	70		
17	Medicinska mikrobiologija s epidemiologijom	Bacteriology, virology and parasitology	60	10	
18	Klinička medicina:	Clinical medicine in relation to nursing care in:			
18a	interne bolesti	General and specialist medicine	53		
18b	infektivne bolesti	General and specialist medicine (infection illness)	35		
18c	bolesti živčanog sustava	General and specialist medicine (neurological illness)	17		
18d	kirurgija	General and specialist surgery	31		
18e	pedijatrija	Child care and paediatrics	31		
18f	ginekologija i porodništvo	Maternity care	31		
18g	psihijatrija	Mental care and psychiatry	31		
18h	bolesti osjetila	Nursing care in dermatology, othorynolarygology and ophthalmology	30		
19	Farmakologija	Pharmacology	35		
20	Socijalna medicina, zdravlje i okoliš	Hygiene: preventive medicine Social and health legislation	62		
21	Zdravstvena psihologija	Psychology	70		
22	Pedagogija	Principles of teaching	70		
23	Hitni medicinski postupci	Urgent medical procedures	32	32	
24	Metodika zdravstvenog odgoja	Hygiene: Health education	32	32	
25	Ljetna stručna praksa nakon III razreda pod nadzorom mentora u bolnici	Summer practice after 3rd High school year, in hospital under supervision of the High school teacher			80
26	Stručna praksa za izradu završnog ispita - odnosi se na temu završnog ispita	Practice in relation to the vocational exam – in relation to the topic of the vocational exam			40

VOCATIONAL EXAM (MATURA in Croatia) *NURSE ENTERS THE NURSES REGISTER BUT CANNOT ENTER AND EXERCISE PROFESSION INDEPENDENTLY*					
CLINICAL NURSING INSTRUCTION (INTERNSHIP in Croatia)					
ZDRAVSTVENA NJEGA U BOLNIČKOJ DJELATNOSTI / HOSPITAL NURSING CARE					
26	Zdravstvena njega internističkih bolesnika	General and specialist medicine (internist patients)	120		360
27	Zdravstvena njega kirurških bolesnika	General and specialist surgery	120		360
28	Zdravstvena njega kod infektivnih bolesti	General and specialist medicine (infective diseases)	40		120
29	Zdravstvena njega bolesnika u ginekologiji i porodništvu	Maternity care	40		120
30	Zdravstvena njega u pedijatriji	Child care and paediatrics (paediatrics)	40		120
31	Zdravstvena njega u neurologiji	Neurological nursing care	20		60
32	Zdravstvena njega u psihijatriji	Mental care and psychiatry	20		60
ZDRAVSTVENA NJEGA U IZVANBOLNIČKOJ DJELATNOSTI / OUT-OF-HOSPITAL NURSING CARE					
33	Djelatnost patronaže i kućne njege	Home nursing	40		120
34	Zdravstvena njega u djelatnosti zaštite predškolske djece	Child care and paediatrics (pre-school child)	10		30
35	Zdravstvena njega u djelatnosti zaštite školske djece	Child care and paediatrics (school-age child)	10		30
36	Zdravstvena njega u djelatnosti za zaštitu zdravlja žene	Maternity and nursing care in health prevention for women	10		30
37	Zdravstvena njega u djelatnosti opće medicine	General and specialist medicine (general medicine)	10		30
STATE EXAM *FINAL EXAM THAT ALLOWS THE PROFESSIONAL GC NURSE TO ENTER AND EXERCISE PROFESSION INDEPENDENTLY* ***Exam consists of general and vocational part. General part deals with legal matters (laws governing health sector) and vocational part deals with whole of the GC Nurses program including the Internship.***					
TOTAL:			2073	117	2013
TOTAL:			3829	423	2043
TOTAL:		4203			
TOTAL:		6296			